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IMPLEMENTING STATE HEALTH CARE REFORM: WHAT HAVE WE LEARNED FROM THE FIRST YEAR? THE FIRST ANNUAL REPORT OF THE EVALUATION OF HEALTH REFORM IN FIVE STATES

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EXECUTIVE SUMMARY

In the early 1990s, states made health care reform a high priority in response to escalating Medicaid costs and increasing numbers of people without health insurance. More and more states began to reform their Medicaid programs through demonstrations authorized by Section 1115 of the Social Security Act. These demonstration programs, which require federal approval, give states great flexibility to modify their Medicaid programs. Most demonstration states aim to control costs through mandatory managed care and to expand eligibility to reduce the numbers of uninsured people. Before 1993, only Arizona had a comprehensive Section 1115 demonstration. By November 1, 1996, 10 states had implemented comprehensive Section 1115 demonstrations, 5 more applications had been approved, and 9 others were under review by the Health Care Financing Administration (HCFA).

Section 1115 demonstrations make major changes in the way health care for the poor is financed and delivered. Consequently, many important policy questions arise: How do the shift to managed care and the expansion of coverage to new groups affect access to care and quality of care? How do these changes affect the structure of the health care delivery system? What can we learn from how these programs are implemented and financed? What is their ability to control costs?

This is the first annual report of a 5-year evaluation that is assessing implementation of five Section 1115 demonstrations and impacts on the beneficiaries covered by the programs. The evaluation is sponsored by HCFA, which is responsible for approving, monitoring, and evaluating the demonstrations. The five demonstration programs being evaluated in this study are (1) Hawaii's QUEST, (2) the Maryland Medicaid Section 1115 Health Care Reform Demonstration, (3) Oklahoma's SoonerCare, (4) Rhode Island's RIte Care, and (5)Tennessee's TennCare. These programs are implementing managed care statewide. Hawaii, Rhode Island and Tennessee have expanded their eligible population to include some uninsured low-income people. This report focuses on program implementation in Hawaii, Rhode Island, and Tennessee, which took place in 1994. It covers the first year of the programs in Hawaii and Rhode Island and the first 18 months in Tennessee. Oklahoma implemented its program in 1996 and Maryland will implement its program in 1997, too late for inclusion in this report.

DATA

Data for this report were collected from documents, focus groups, and interviews with key persons in each state. Interviews with state officials, staff of managed care organizations (MCOs), providers, legislators, and advocacy organizations, as well as focus groups with consumers and physicians, took place during two 1 -week visits to each of the states in mid- 1995. Documents were provided by HCFA, the states, MCOs, providers, and others.

BEFORE THE DEMONSTRATIONS

These three states applied for Section 1115 demonstrations for similar reasons:

- Medicaid costs had been increasing, and they wanted to control costs and improve the cost-effectiveness of their programs.
- They were concerned about reducing the uninsured population.
- They wanted to take advantage of the administration's support of expedited demonstration approvals.

However, their immediate motivations differed. In Hawaii, QUEST was designed to integrate three state insurance programs. The state had been moving toward universal health insurance long before QUEST and had the lowest level of uninsured people in the nation. So, Hawaii focused on slowing growth in Medicaid costs by enrolling participants in MCOs. It also focused on increasing federal matching of state expenditures by integrating its General Assistance program and the State Health Insurance Program (SHIP), a program for low-income uninsured people, with the Medicaid program for nonelderly and nondisabled people. The goal of program integration was to provide seamless coverage, with consistent eligibility criteria and benefits, and to ensure that the two state programs could receive federal matching funds. Rhode Island's program goals grew out of concerns about primary care access problems in the Medicaid program, illustrated by the high proportion of expenditures on inpatient hospital stays and excessive use of emergency rooms for primary care. Additionally, increases in unemployment resulted in increases in the number of people without health insurance. Tennessee, which was anticipating the end of the state's hospital tax in 1993 (the basis for disproportionate-share hospital funding), believed new taxes were politically infeasible, and needed a way to solve its budget crisis. Furthermore, 16 percent of people under age 65 in the state lacked health insurance, and the state was eager to expand insurance coverage for this group.

Before the demonstrations, the health service delivery systems in the three states varied considerably. These contrasting markets influenced state program development, approaches to capitation rate setting, and ease of implementation. Managed care penetration in Hawaii and Rhode Island was above the national average, at 23 percent and 26 percent of the insured population enrolled in health maintenance organizations (HMOs), respectively. By contrast, Tennessee had little managed care penetration; only 6 percent of the insured population was enrolled in HMOs. However, managed care was a small part of the Medicaid program in all three states (four percent or fewer of Medicaid enrollees were voluntarily enrolled in HMOs). Hospital bed supply was greatest in Tennessee, which had a high proportion of beds per person and low occupancy rates, and lowest in Hawaii, which had a low proportion of beds per person and high occupancy rates. In Tennessee, Medicaid payments to physicians were relatively generous, as a result of increases in the 1980s to improve access. By contrast, physician payments in Rhode Island were very low, and one demonstration program goal was to improve Medicaid physician payments and participation. A unique feature in Rhode Island was that community health centers served one-quarter or more of Medicaid recipients.

PROGRAM CHARACTERISTICS

Design and Implementation Schedules. The three states designed their programs rapidly. They received demonstration approval within 5 months after applying and implemented their programs between 6 weeks later (Tennessee) and 12 months later (Hawaii).

State	Application Submitted	Application Approved	Program Implemented
Hawaii	April 19, 1993	July 16, 1993	August 1, 1994
Tennessee	June 16, 1993	November 18, 1993	January 1, 1994
Rhode Island	July 20, 1993	November 4, 1993	August 1, 1994

Eligibility, Service Coverage, and Enrollment. All three demonstrations introduced statewide managed care during 1994, covering all or part of the traditional Medicaid population as well as new populations that were previously ineligible. Tennessee's program was the largest and most inclusive, and Rhode Island's, the smallest and least inclusive. All three programs required people in the expansion group with incomes above a threshold to pay part of their costs. In Tennessee, the threshold was family incomes above 100 percent of the poverty level; in Hawaii and Rhode Island, it was family incomes above 133 percent of the poverty level (or above 185 percent of the poverty level for pregnant women and infants).

State	Medicaid Groups Included	Expansion Group Included	Enrollment After One Year
Hawaii (QUEST)	AFDC-related and poverty-related groups	Nonelderly, nondisabled uninsured people with incomes under 300 percent of the federal poverty level[b]	157,000
Rhode Island (RIte Care)	AFDC-related and poverty-related groups	Uninsured children under age 6 and pregnant women with family incomes under 250 percent of the federal poverty level	70,000
Tennessee (TennCare)	All groups except qualified Medicare only beneficiaries	Uninsured people (with subsidies up to 400 percent of the poverty level) and medically uninsurable people	1,25 1,000

[a] In 1996, Hawaii restructured the QUEST program to reduce participation and expenditures greatly.
[b] Most of the newly eligible population was already covered under state General Assistance and SHIP.

The demonstrations maintained or expanded the benefits provided under Medicaid. TennCare eliminated Medicaid limits on physician services, outpatient visits, home health visits, and prescriptions. It also added adult psychiatric inpatient coverage. Although QUEST covered the same benefits as Medicaid, these benefits were more generous than those provided by SHIP. RIte Care added a comprehensive package of family planning benefits for 2 years to women who would otherwise have become ineligible for Medicaid 60 days postpartum. It also added nonemergency transportation, interpreter services, childbirth education, parenting education, nutrition counseling, and smoking cessation classes.

Participants in all three states had to choose an MCO when they enrolled in the demonstration. In Tennessee and Hawaii, initial program enrollment was by mail, with no counseling provided, and everyone in the covered Medicaid population was enrolled in managed care all at once. Rhode Island's process was more personalized; the state tried to counsel Medicaid participants in person, and enrolled them in RIte Care during a 12-month period.

Managed Care Contracting. Although the process varied, all three states contracted with enough MCOs in different areas so that all participants had a choice between at least two MCOs. All MCOs received capitation payments from the state to serve the enrolled populations.

Hawaii and Rhode Island requested proposals from MCOs, and then negotiated capitation rates with each one individually. Both states contracted with five HMOs (one of which was formed by federally qualified health centers [FQHCs]). Hawaii also contracted with two dental MCOs and two behavioral health MCOs. In Tennessee, there was no formal request for proposals from MCOs. The state drew up two standard contracts (one for HMOs and one for preferred provider organizations--PPOs). Seven HMOs and five PPOs signed these nonnegotiable contracts. Tennessee paid the same capitation rates to all MCOs (although rates varied by member characteristics).

State	Number of MCOs	Number of Newly Formed MCOs	FQHCs Formed an HMO?	Number of Statewide MCOs
Hawaii	5	1	Yes	1
Rhode Island	5	1	Yes	5
Tennessee	12[a]	5[b]	No	2[c]

[a]Five of the MCOs were PPOs.
[b]Three of the five new MCOs were sponsored by teaching hospitals.
[c]In 1996, a third MCO was offered statewide.

During the first year, capitation rates per member, per month, averaged $115 in Rhode Island and $188 in Hawaii (Hawaii's rate included dental coverage). Tennessee set an average payment rate and then discounted that rate to include expected savings from managed care and to share with providers the savings accruing from reduced numbers of uninsured people. After discounting, the payments averaged about $101 per member, per month, during the first 6 months of TennCare.

In Tennessee, the five PPOs have until 1997 to implement primary care gate-keeper arrangements, so many enrollees and providers are not yet subject to standard managed care practices. (These PPOs are simply limited providers networks; they do not allow members to use out-of-plan providers.) In the other two states, primary care gate keepers are required Tennessee also allowed MCOs more freedom than the other states to market to enrollees. For example, MCOs could market door-to-door and, with permission, in welfare offices where people apply for Medicaid.

Budget Neutrality and Financing. A condition of demonstration approval was that it be budget neutral to the federal government during the 5-year demonstration period. To varying degrees, each state assumed it could slow growth in Medicaid program costs and use some of the savings to serve more people. Tennessee and Hawaii ended their disproportionate-share payments to hospitals, freeing up federal funds for program expansion. Hawaii and Rhode Island assumed that they would have served women and children covered under Section 1902(r)(2) provisions in the absence of the demonstrations. This assumption allowed them to increase their "baseline" costs against which budget neutrality was measured. Tennessee planned the largest expansion and needed the greatest relative savings per person to finance it. Although Hawaii had to stretch its federal dollars to serve more people, it also hoped to save some state funds from the SHIP program to support expansion. Rhode Island planned the smallest expansion.

Moreover, because all of the expansion group could have been eligible for Medicaid under section 1902(r)(2) provisions, Rhode Island's program did not depend on savings from managed care to finance the expansion group. The state budgets and expected savings were as follows:

State	Initial 5-Year Budget (Millions)	Expected Federal Savings (Millions)	Expected State Savings (Millions)
Rhode Island	$708	$1.3	$1.1
Hawaii	$1,291	$5.4	$429
Tennessee	$19,600	$3,200	$1,600

Hawaii expected to save state funds through incorporating state programs (SHIP and General Assistance) in the QUEST program and getting federal matching payments. RIte Care financed its demonstration by keeping the current Medicaid budget intact and appropriating an additional $6.5 million to cover the expanded population and the administration of RIte Care. In addition, some Department of Health program funds were shifted to RIte Care. Both states assumed that the program would receive funds from enrollee premiums and copayments.

To finance the state share of the TennCare budget ($8 billion), Tennessee planned to draw on a variety of sources, most of which were eligible for federal matching payments. These sources included the state general fund, other state health programs, certified public expenditures (basically, uncompensated care costs in public hospitals for Ten&are-eligible persons not enrolled), premium payments from enrollees, a nursing home tax, and local government subsidies for indigent care. The state also included the costs of provider charity care in its budget (these costs were not federally matched). Capitation payments to MCOs were reduced to reflect the provider charity contribution.

Program Administration. The administration of the three programs differed. In Hawaii, the Med-QUEST division of the Department of Human Services assumed some of the responsibilities of the Department of Health, which had administered SHIP. The Med-QUEST Division also took primary responsibility for QUEST enrollment functions, which welfare staff had previously handled. This required the division to hire and train workers to assess eligibility and enroll participants into MCOs. RIte Care made the largest structural change; it is run by the Office of Managed Care, which was initially staffed jointly by the Department of Health and the Department of Human Services, as well as an outside contractor. An executive committee made up of the directors of the Departments of Health, Human Services, and Administration, as well as a representative of the governor, oversaw the Office of Managed Care in the first year. RIte Care is now operated by the Department of Human Services. In Tennessee, the Medicaid Bureau was renamed the TennCare Bureau. The state also added an eligibility determination contractor for the newly covered uninsured and uninsurable groups.

IMPLEMENTATION EXPERIENCE

Although it is too early to determine the impacts of these three demonstrations on beneficiaries, we can draw the following conclusions about program implementation.

Programs were designed quickly, providing limited opportunities for consultation with stakeholders. Opportunities for input to program design were limited in all three states because of the speed with which the demonstration applications were developed and submitted. To some degree, this caused problems in all three states. In Tennessee, interested groups had opportunities to meet with the governor before the demonstration application was submitted for approval, but their comments were largely ignored since they were opposed to key program elements. Physicians became angry when the state ignored their views, and the state's medical association tried to block TennCare through legal action. MCOs were able to review drafts of the MCO contract, and some consumer groups met with the state biweekly from June to December 1993. However, the first public hearings on TennCare took place in 1995, one year after TennCare began. In Hawaii, there was also little opportunity for public input. Physician groups objected both to the process and the focus on managed care, and legislators threatened to block implementation. In Rhode Island there appeared to be little provider concern about the move to managed care, except among FQHCs, but consumers and their organizations criticized the state for not involving them more in the design. As a result, RIte Care staff made many efforts to involve consumer advocates during implementation planning and the first year of operations. At the national level, the National Association of Community Health Centers sued HCFA to stop implementation of Section 1115 demonstrations.

Program startup was troubled All three states had implementation problems at startup, although the amount of confusion varied with the size of the program, the speed of implementation, and the scope of the changes. Enrollment-related problems occurred in all three states. There were delays between application and MCO enrollment, MCOs could not reconcile discrepancies between their membership records and the state's, consumers encountered problems or were confused about how to enroll in the program or select MCOs or physicians, providers could not always tell which MCO their patients were enrolled in, and enrollment of pregnant women and newborns was not always smooth.

The TennCare program enrolled three-quarters of a million people into MCOs on January 1, 1994. Administrative problems accompanied this considerable achievement. These problems were exacerbated by the brevity of the period between program approval and implementation, and the lack of managed care experience in the state. Despite hard work by state arid MCO staff, the necessary eligibility and claims processing systems were not working smoothly on January 1, 1994. In addition to confusion about enrollment, the state was not ready to oversee MCOs. Moreover, some MCOs ran into provider network problems. The largest TennCare MCO (Blue Cross) initially lost one-third of its physician network because physicians objected to the MCO's requirement that they accept TennCare patients if they continued to accept state employees, This situation led to difficulties getting access to some specialists. Throughout the first 18 months, the second largest TennCare MCO (Access MedPlus) had major problems paying provider claims and required close monitoring by and help from the state.

Hawaii's much smaller program was also challenged by the volume of eligibility applications it had to handle at the start of QUEST and the inexperience of the staff handling this function. Because of the ensuing application backlogs, applicants had to wait more than a month to get an appointment for eligibility determination. The state had anticipated a wait of only 10 days, during which it would pay fee-for-service for services applicants received. The prolonged delay led to problems for the state in deciding how to provide coverage during the waiting period. Furthermore, many beneficiaries had to change physicians unnecessarily.

Rhode Island was criticized for implementing RIte Care before everything was ready. Even though enrollment into managed care was phased in during a 12-month period, the state's eligibility system still

had problems, causing confusion for providers and consumers. RIte Care placed new demands on the state's Medicaid Management Information System (MMIS), which had only been implemented in December 1993. Furthermore, because the HMO formed by the FQHCs was not licensed when RIte Care began, it requested a delay in RIte Care implementation. Instead, the state allowed enrollees choosing this plan to remain in fee-for-service Medicaid until the plan received its license. The HMO believed this had a negative effect on its enrollment. Other HMOs considered this an unfair advantage, and one threatened to sue the state.

States were able to attract MCOs and retain their participation. Despite states' limited experience with Medicaid managed care, they were able to contract with capitated managed care plans quickly. Each state included new MCOs, some formed by FQHCs, others by teaching hospitals. MCO operations appear to have been reasonably smooth in Hawaii and Rhode Island. Some MCOs in Tennessee were not fully developed at startup, however, because of the brief planning period, the lack of managed care experience, and the absence of a strong state licensing mechanism for MCOs.

All of the initial MCOs were still operating 12 months after startup (18 months in Tennessee), but we are unable to predict their long-term viability at this point. While the Rhode Island MCOs did not provide details, they indicated losing money in the first year, though none was insolvent as a result. The state intended to change the MCOs' contracts in Year 2 to improve consumer access to services. Provider reimbursements for pregnancy care and delivery have already increased. In Tennessee, none of the MCOs reported making much money in the first year, and some reported losses. Eighteen months after startup, the state increased capitation rates by 9.5 percent rather than the 5 percent increase scheduled in the contracts. The MCO contracts were renewed after 18 months with stiffer penalties for failure to report accurate encounter data to the state and diverse additional requirements to provide ongoing managed care education. In contrast, all MCOs in Hawaii appeared to make money during the first year. The state renegotiated capitation rates after one year, reducing them slightly. As QUEST started its second year, the state also capped enrollment in the largest plan to ensure adequate enrollment in the other plans (so that the other plans would stay viable).

Provider payments relative to Medicaid varied across the three states. MCOs set provider payment methods and amounts, subject to the capitation payment rates the state paid. In Hawaii, payments appeared to be about the same as under Medicaid. In Rhode Island, payments to primary care physicians appeared to be higher, as intended. With the exception of primary care physicians in some plans, Tennessee providers reported lower payment rates than under Medicaid.

In Hawaii, program payment levels did not appear to change much from Medicaid rates. It was too early for hospitals to determine how QUEST had affected them, although there were no dramatic initial effects. Payments to hospitals by MCOs often included disproportionate-share hospital supplements.

RIte Care intended to improve primary care physician participation by increasing payment rates, and early signs are that it has been successful, although there were initial concerns about participation in parts of the state. Hospitals felt it was too early to assess RIte Care's impacts on their finances, but all 15 hospitals in the state were participating in it After extended debate, the state decided that MCOs have to pay hospitals for emergency room screening (also an important issue in the other two states).

Tennessee providers' reports of low payments by MCOs are consistent with the deeply discounted capitation payment to MCOs. To assist providers in the transition to managed care, Tennessee provided supplemental provider payments during the first year. Nevertheless, cash flow worsened under TennCare

(a small sample of hospitals reported that the days in net accounts receivable doubled under TennCare, compared to Medicaid). Major changes in the amounts providers are paid under TennCare have led to concerns about and actions to sustain the viability of some safety net providers. Most notably, the Regional Medical Center in Memphis ("The Med") received a special payment of $12 million in 1995 to assist its transition to managed care and to ensure continued access for vulnerable populations.

FQHCs lost cost-based reimbursement in these programs, which was a serious problem for them. As a result of FQHC pressure, Rhode Island pays a supplemental fee of $10 per member, per month, to FQHCs for each participant who selects that FQHC as a primary care site. The supplement was intended to assist FQHCs in the transition to managed care. Hawaii also provided a temporary FQHC supplement.

Providers had to adjust and experienced some administraiiveproblems. All three demonstrations required new MCOs to develop health care provider networks rapidly. They also required providers to adapt their clinical and administrative practices as the Medicaid program changed from largely fee-for-service to managed care. All types of providers in all three states complained about the lack of managed care education for consumers, who did not understand their obligations to use primary care gate keepers or conditions under which they should use emergency rooms.

Providers in all three states were critical of administrative problems (especially uncertainty about patient eligibility). In Hawaii and Tennessee, primary care physicians spoke of difficulties in making referrals to specialists because of low specialist participation. Hawaii's physicians were also concerned about disruption of patient relationships when MCOs arbitrarily assigned patients to physicians regardless of their choices. These physicians lost a lot of old patients but gained many new ones. In Tennessee, providers complained of slow payments and frequent payment denials by MCOs. But, within 15 months of TennCare implementation, some facility-based providers had begun to use their market power to act on problems, such as lack of timely payment. All providers indicated that administrative problems with payments were at least as problematic as low payments.

In Rhode Island, participation in a commercial HMO contracting to serve RIte Care enrollees obligated physicians to take part in the demonstration. This requirement, known &mainstreaming, apparently caused few problems for physicians. In Tennessee, the same requirement in the Blue Cross provider network upset physicians considerably. Physician participation in QUEST was entirely voluntary.

Low-income consumers appeared satisfied with the demonstrations, although disabled and chronically ill consumers were less ***satisfied***. In focus groups, disabled and chronically ill consumers appeared slightly less satisfied with the programs than low-income consumers, because of greater concerns about access to specialists and emergency care. (This may have been true under fee-for-service too.) The relatively low rates of plan switching (10 percent or less) during the first open enrollment period support these reports. Despite their overall satisfaction, consumers in all three states identified problems with the eligibility and enrollment processes (some had not understood initially that they were supposed to choose an MCO and a primary care physician, and some had delays in receiving care because of enrollment problems). RIte Care consumers were especially pleased with the greater choice of places to receive care than under Medicaid (some had transferred from clinics to private doctors) and the removal of the stigma associated with being on Medicaid. (However, some Rhode Island physicians were concerned that consumers switching from FQHCs to private practitioners might not receive all the support services they needed.) By contrast, Hawaii and Tennessee consumers complained about physician choice (in Hawaii, consumers objected to losing their previous doctors and dentists, even when the provider participated in the plan and was requested by the consumer). Tennessee consumers mentioned problems, with prescription

drug coverage and access to primary care physicians and dentists. RIte Care participants said that restrictions on emergency room access left them puzzled about what constituted a genuine emergency.

Tennessee and Hawaii had budgetproblems in the first year. Tennessee was unable to raise all of the budgeted state funds during the first year of TennCare and thus could not receive the maximum federal matching payment allowed. Because of these problems, the state closed enrollment in the program for the uninsured at the end of 1994 to everyone except people losing Medicaid eligibility and medically uninsurable people; enrollment had not reopened as of December 1996.

QUEST participation was 40 percent higher than initially planned, partly because of unexpected program popularity and partly because of a statewide recession, leading to serious budget problems. In 1995 and 1996, the state took increasingly stem measures to rein in costs by restricting eligibility and lowering capitation payments to MCOs.

In the first year, Rhode Island appeared to underspend its per member, per month, targets. It enrolled only 1,000 people in its expansion group, one-tenth of the expected number. The implications are still being worked out, but the underspending may be due to different demographic characteristics in the enrolled population than projected. It could also mean that capitation payments were set too low, as MCO representatives have claimed.

The state monitoring process for MCOs was still being developed States are responsible for monitoring MCOs to ensure that they fulfill their contracts. Quality improvement monitoring was still in the developmental stage in Hawaii and Tennessee. These states concentrated on more basic operational problems during the first year than Rhode Island, which had well-developed state quality improvement standards. To monitor plan performance, the states need accurate encounter data (which are also required for the evaluation). Eighteen months after startup, none of the states had produced final encounter data for the first year, which limited their ability to monitor MCO performance during startup.

The states are modifying program administration and MCO requirements in response to problems. Because of implementation problems, states are modifying both program administration and MCO requirements, although they have retained basic program structures. In addition to restricting program eligibility, the division of Med-QUEST in Hawaii made two important administrative changes: it developed a special unit for expediting certification of pregnant women, and it arranged to station eligibility workers at FQHCs. By the end of the first year, Hawaii had greatly reduced the waiting time between application and enrollment. In Rhode Island, the state moved the Office of Managed Care into the Department of Human Services to facilitate RIte Care administration and it took steps to expedite enrollment of newborns, which had been problematic. It also made or plans to make several operational changes in response to first-year experiences, including requiring MCOs to pay for an emergency room screening that determines whether a visit is an emergency. In early 1995, the new governor of Tennessee transferred the TennCare Bureau from the Health Department to the Department of Finance and Administration to reflect de facto reporting lines. He also added an assistant commissioner and supporting staff to the Department of Commerce and Insurance to strengthen oversight of TennCare MCOs. Eighteen months after TennCare began, the state made an unscheduled increase in the capitation rate, in response to criticisms that the rate was too low, and added terms to MCO contracts to improve encounter data reporting and ongoing managed care education.

LESSONS FROM STARTUP

A number of constituencies can learn from the startup of the Section 1115 demonstrations in Hawaii, Rhode Island, and Tennessee. 'These constituencies include the federal government, the participating states, other states that may be planning Section 1115 demonstrations, MCOs, providers, and consumers. The lessons below, drawn from startup experience, may help these constituencies understand their options and the most efficient ways of meeting their goals.

States can implement major changes in a short period The three demonstration states implemented major changes in a year or less. These changes resulted from the combined efforts of state and federal agencies, MCOs, health care providers, and advocates. In varying degrees, each state provided health insurance to new groups that would otherwise have remained uninsured.

More time is needed for planning and implementation. In Tennessee, an array of problems resulted from rapid implementation. Both Hawaii and Rhode Island took about a year after approval to implement their programs and still encountered difficulties, albeit less severe ones than Tennessee's, Consumers are more confused when managed care enrollment occurs statewide all on one day (as in Hawaii and 'Tennessee). Although Rhode Island's rolling implementation schedule also had shortcomings, it did not tax staff capacity to the same extent.

States can expand Medicaid managed care rapidly, although it is too early to assess the implications for quality of care and MCOs' long-term financial stability. An initial evaluation question was whether existing MCOs would participate or whether new MCOs would be formed to participate, since these states had limited Medicaid managed care experience. None of the states had difficulty getting plans to participate, and some new MCOs were developed explicitly for the programs. Some of the new MCOs, such as those owned by federally qualified health centers and Medicaid-only plans, could not have been formed under standard federal rules (though they could operate for up to 3 years under Medicaid 1915(b) waivers). The MCOs that served the most patients used network-style managed care. They were eventually able to form both urban and rural networks, although access problems occurred initially in some areas and physician specialties (some of which continue). The longer planning periods in Hawaii and Rhode Island, and Rhode Island's strong state licensure requirements, appeared to ease the transition to managed care. The lack of managed care infrastructure in Tennessee seems to have created problems, suggesting that states need to review MCOs' readiness before startup and consider limiting their enrollment until they prove they can operate smoothly. It is too early to assess MCOs' quality of care or long-term financial stability.

States need more administrative resources during startup. In the short term, states may require more (and different) staff to implement managed care demonstrations than they do to manage fee-for-service Medicaid programs. All the states initially had staff shortages, especially in enrollment and consumer relations. States used consultants constructively to help design and manage program elements, such as managed care contracting and capitation rates, thus adding expertise that was not available internally. From the start, states need to develop automated data systems to track enrollment in MCOs. States may have underestimated the necessity for the types and amounts of resources needed to monitor MCOs. In states with little managed care experience, MCO start-up problems can be serious and long-lasting. Rhode Island, which had the strongest managed care market and the most developed HMO licensure requirements, had far fewer initial MCO problems than Tennessee.

Procedures for enrolling pregnant women and newborns may need to be modified under managed care. All three states encountered snags in enrolling one or both of these groups in managed care, which threaten access to care. All states have improved the process by which newborns are assigned to the same MCO as the mother, and Hawaii added a unit to expedite certification of pregnant women.

Consumers need more education about managed care. Enrollees often did not understand their choices among MCOs or how managed care worked. Only Rhode Island made any serious attempts at patient education in the first year, but even there, providers felt that more ongoing education was needed. Unbiased enrollment counseling is critical when a program starts and word-of-mouth advice within the community is scant. At a minimum, states should have accurate directories of participating physicians available to help enrollees select MCOs. Ongoing education is needed to explain managed care practices, such as how to use primary care gate keepers and when to use the emergency room.

Safety net providers may need special support Experiences in Tennessee suggest that, if states want the safety net hospitals to continue to serve vulnerable populations, they may need to make special arrangements to help them in the transition to managed care. Experiences of some FQHCs in all three states indicate that their ability to continue to serve the remaining uninsured people may be compromised by lower payments, even when states make supplementary payments.

Budget problems may undermine expansions. Both Tennessee and Hawaii suffered unanticipated budget problems. Tennessee was unable to raise enough funds for the state share of the budget. It was forced to curtail enrollment of the uninsured after one year and to make a number of budget adjustments in the first and second years. Hawaii's participation level was much higher than expected, forcing program cutbacks in the second and third years.

Controversy can be resolved through increased communication. In all three states, startup was accompanied by controversy. Conditions appeared more stable and less controversial by the end of the first year (18 months in Tennessee). Key factors in the improvements were flexibility in solving problems and increased communication among the state, MCOs, health care providers, other stakeholders, and consumers.

Despite start-up problems, these demonstrations survived political changes. These types of programs are not abandoned easily after startup. In all three states, new governors have been elected (two from the opposing party). They have made no move to dismantle the programs but have committed their support to them and, in some cases, have made important administrative improvements.

I. BACKGROUND AND PURPOSE

In the early 1990s, the dual problems of escalating Medicaid costs and increasing numbers of people without health insurance made health care reform a high priority in many states. A principal way of implementing such reform is through waivers to the Medicaid program authorized by Section 1115 of the Social Security Act: the research and demonstration waiver program.[1] States apply to the federal government for waivers to allow them to modify their Medicaid programs in an attempt to ameliorate their problems with Medicaid costs and uninsured populations. As of November 1, 1996, 10 states had implemented comprehensive Section 1115 demonstration programs, 5 more had been approved, and 9 others had applied and were under review.

The Health Care Financing Administration (HCFA) is evaluating the Section 1115 demonstration programs through a contract with Mathematica Policy Research, Inc. (MPR) and its subcontractor, the Urban Institute. This is the first of four annual reports of an evaluation of five states that have Section 1115 waivers for their Medicaid programs. The 5-year evaluation will assess how the following Section 1115 demonstrations were implemented and what their impacts were on the beneficiaries of service (programs are listed in order of implementation):[2]

- The Tennessee TennCare program (implemented January 1, 1994)
- The Hawaii QUEST program (implemented August 1, 1994)
- The Rhode Island RIte Care program (implemented August 1, 1994)

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[1] Social Security Amendments of 1965, Public Law No. 80-97 (amending 42 U.S.C. 1315 (a)(l)),

[2] In addition to the evaluation of the overall impacts of the Section 1115 demonstration programs, MPR is also evaluating the effect of the demonstrations on persons with disabilities, including mental health and substance abuse disorders. This work is being funded by the Assistant Secretary for Planning and Evaluation (ASPE), and by the Substance Abuse and Mental Health Services Administration (SAMHSA).

- The Oklahoma Sooner&t-e program (implemented April 1, 1996)
- The Maryland demonstration programs (to be implemented January 2, 1997)

These five programs are all implementing managed care on a large scale, and three of them have expanded their eligible population to include uninsured low-income people. This report focuses on the implementation of the demonstration programs in Hawaii, Rhode Island, and Tennessee, which implemented their programs in 1994. The other two states implemented their programs too late for study in the first year.

A. INTRODUCTION TO THE SECTION 1115 DEMONSTRATION PROGRAM

A variety of issues fueled the rapid, recent growth in the Section 1115 demonstration programs: national health care reform discussions, states' desire for greater flexibility in operating their programs, and expansions in managed care. National health reform seemed likely as a result of the public support for it during the 1992 presidential election campaign. Meanwhile, states were urging the federal government to give them greater freedom to experiment with federally funded health and social welfare programs. Welfare reform programs and block grant financing mechanisms were, increasingly often proposed. Then, the President, in working with the National Governors' Association, promised a faster waiver approval process for Section 1115 demonstrations. In this setting, more states began to consider and apply for Section 1115 waivers for their Medicaid programs. Because of the widespread growth of managed care and the expected savings resulting from it, the states' applications included strong managed care components.

A variety of Medicaid program waivers are available to states; this evaluation focuses on the broadest of these--the Section 1115 research and demonstration program. A Section 1115 waiver gives a state great, but not unlimited, flexibility to restructure its Medicaid programs if the demonstration "is likely to

assist in promoting the objectives of the [Medicaid] program."[3] For example, a state can change eligibility standards, thereby allowing it to cover populations such as single adults and working families that traditionally have been excluded from Medicaid. A state can also change the "amount, duration, and scope" of benefits it offers and can limit beneficiary choice of health care providers. This allows the state to mandate enrollment in managed care. States can request a waiver of the normal Medicaid requirement that no more than 75 percent of a managed care organization's (MCO's) members are Medicaid or Medicare enrollees. In addition, a state can seek waivers on how providers are reimbursed. For example, the Section 1115 waiver authority allows states to waive the Medicaid cost-based reimbursement of Federally Qualified Health Centers. The five states in the evaluation have sought and received exemptions in all key program dimensions: eligibility, benefits, freedom of choice of provider, provider reimbursement, and financing.

Since the Administration announced a streamlined process for approving Section 1115 waivers in August 1993, there have been 23 new applications or approvals. This excludes Arizona (which had operated under a Section 1115 waiver since 1982), Oregon (which applied in 1991 and was approved in March 1993) and Hawaii (which applied in April 1993 and was approved in July 1993). Among the 23 states, 13 applications have been approved (although 1 --South Carolina--has been indefinitely postponed), and 8 have been implemented (including all of the evaluation states except Maryland). Table I. 1 lists all the states that have ever applied for or received a comprehensive Section 1115 waiver.

The statutory authority provides no guidance about the Section 1115 waiver approval process beyond a description of the statutes that can be waived. However, during the past 2 years, HCFA has published procedures for states to follow. A *Federal Register* announcement on September 27, 1994, described the principles that HCFA will follow in approving or disapproving Section 1115 waiver applications *(Federal*

[3]The Section 1115 demonstration program allows primarily for waivers of the statutes of Sections 1902 and 1903 of the Social Security Act.

TABLE I. 1

SECTION 1115 WAIVER APPLICATIONS AND APPROVALS

State	Applied	Approved	Implementation Date	Comments
Alabama	7/10/95			Under review
Arizona	1. 1982	1. 1982	1. 10/1/82	
	2. 3/17/95 (Amendment)			2. Amendments under review
Delaware	7/29/94	5/17/95	1/1/96	
Florida	2/9/94	9115194		No implementing legislation
Georgia Behavioral health	9/1/95			Under review
Hawaii	**4/19/93**	7116193	**8/1/94**	
Illinois	9/14/94	7/12/96		
Kansas	3/23/95			Under review
Kentucky	1. 5/26/93	1. 12/9/93		
	2. 6/22/95 (Amendment)	2. 10/6/95		
Louisiana	12/31/94			Financial proposal disapproved 6/8/95
Maryland	**5/3/96**	**10/30/96**	**1/2/97 (proposed)**	
Massachusetts	4/15/94	4/24/95		
Minnesota	7/27/94	4/27/95	7/1/95	
Missouri	6/30/94			Under review
Montana Behavioral health	6/15/95			Disapproved 9/1 3/95
New Hampshire	6/14/94 (Revised proposal submitted 6/5/96)			Under review
New York	3/20/95			Under review
Ohio	3/2/94	1/17/95	7/1/96	
Oklahoma	**1/6/95**	**10/12/95**	**4/1/96**	
Oregon	8/15/91	3/19/93	2/ /94	Amendments under review

TABLE I. 1 *(continued)*

State	Applied	Approved	Implementation Date	Comments
Rhode Island	**7/20/93**	**11/1/93**	**8/1/94**	**Amendments under review**
South Carolina	3/1/94	11/18/94		Indefinitely postponed 4/95
Tennessee	6116193	11118193	**1/1/94**	**Amendments under review**
Texas	9/6/95			Under review
Utah	7fl19.5			Under review
Vermont	2/24/95	7/28/95	1/1/96	Amendments under review

SOURCE: HCFA list titled "Comprehensive Health Care Reform Demonstrations;" dated September 25, 1996, updated to include the subsequent approval of Maryland's application.

NOTES: 1. Three additional states and the District of Columbia were in pre-application status on September 25, 1996: New Jersey, Pennsylvania, and Washington.

2. States in bold are in the evaluation.

*Kentucky amended its original proposal to implement the "Kentucky Partnership Plan," which divides the state into eight managed care regions to form a single managed care network, offering the Standard State Medicaid benefit package to non-institutionalized beneficiaries. Mental health and long-term care will remain in a fee-for-service system.

Register 1994). This announcement describes HCFA's commitment to assessing the state's ability to implement the program, instituting a meaningful policy of evaluation, maintaining the principle of cost neutrality over the life of the demonstration, minimizing the administrative burden on the states, and reducing processing time for waiver requests. In addition, HCFA expects states to provide for meaningful public input into the Section 1115 proposals and recognizes that it takes time to test a new policy and evaluate it. HCFA also developed a guide for its staff to use while reviewing state applications (Health Care Financing Administration 1995a) and a proposal guide for states to use (Health Care Financing Administration 1995b).

HCFA now encourages the states to submit brief concept papers before submitting a complete application. States must then submit an application with narrative describing the changes in program eligibility, benefits, and structure; an implementation plan; and a budget for the period of the waiver showing state and federal funding levels and anticipated savings. HCFA, in cooperation with the state, sets a schedule with target dates for decisions and shares terms and conditions with the states before they are finalized. These terms and conditions describe the mandated features of the Medicaid program that are being waived and conditions of approval (such as the negotiated budget with the federal costs and a description of which state funding sources will be matched by federal dollars). They also discuss such conditions as providing encounter data for the evaluation and conducting surveys of quality and beneficiary satisfaction. Since it was streamlined in 1993, the waiver process has averaged 268 days from application to approval.[4]

The U.S. Department of Health and Human Services (DHHS) has required the Section 1115 demonstration programs to be budget neutral to the federal government. Budgets may be budget neutral over the life of the demonstration instead of budget neutral in every year of the demonstration. Budget

[4]This is the average for the 13 states approved since August 1993, including South Carolina, whose program has been indefinitely postponed.

neutrality is typically an important issue in negotiating waiver approval. The federal government shares in the costs of the Medicaid program, paying half or more of approved costs. States may not propose programs that will result in federal costs any higher than they would have been if the demonstration program had not been implemented. Thus, the states must develop demonstration budgets and budgets showing what the costs would have been without the demonstration, and they must spell out the assumptions underlying each budget. These budgets make assumptions about the growth rate of the eligible and enrolled population and the program costs over the life of the demonstration. Furthermore, states may assume that, had they not applied for the Section 1115 waiver, they would have increased their Medicaid program costs by making changes in eligibility under the Section 1902(r)(2) provisions. Such changes would increase the income level at which low-income pregnant women and children are covered under Medicaid. If states assume they would have introduced such Section 1902(r)(2) coverage, their baseline (predemonstration) federal cost estimates would have increased above the actual levels incurred. States may, however, only assume coverage under 1902(r)(2) provisions if the Section 1115 demonstration actually covers these populations. The General Accounting Office has questioned whether the demonstration spending limits HCFA approved for some Section 1115 demonstrations are actually budget neutral (General Accounting Office 1995d). We will assess the costs of each of these demonstrations over the long term and make our own evaluation of whether the demonstrations were budget neutral to the federal government.

Responsibility for waiver approval lies with the Secretary of DHHS. Responsibility for approval has been delegated to the HCFA Administrator, who seeks review from other federal agencies. After approval has been given and the program is implemented, HCFA's central and regional offices are responsible for monitoring the demonstration program.

B. KEY FEATURES OF THE FIVE STATE DEMONSTRATION PROGRAMS TO BE EVALUATED

All but Maryland and Oklahoma have expanded the population covered through their Section 1115 demonstrations. Tennessee's demonstration program allows the state to cover any uninsured person without income limits (with subsidies up to 400 percent of the federal poverty level), as well as medically uninsurable people. Hawaii's expansion group is limited to people under 300 percent of the federal poverty level and focuses on those people previously enrolled in two state health insurance programs for low-income people. Rhode Island's expansion group was initially limited to children under age 6 and pregnant women under 250 percent of the federal poverty level. Table I.2 shows the populations that are included in the demonstrations and the services covered.

The five states being evaluated are all committed to large-scale enrollment of their Medicaid populations into managed care in their demonstrations. The managed care design varies with the local market features, which include the level of preexisting managed care and supply of providers. Except in Oklahoma, the managed care model is the same throughout the state. In Oklahoma, rural and urban areas will use different models of managed care. Tennessee has enrolled its entire Medicaid population into managed care;[5] Rhode Island has limited managed care enrollment to pregnant women, children, and their parents; and the other states he between these extremes, with planned phase-ins of different populations or services over time. Table I.3 summarizes the managed care features of the five states' demonstrations.

The programs vary in size, depending on the number of beneficiaries eligible for Medicaid prior to the demonstration, which Medicaid eligible groups are included in the demonstration, and the size of the expansion group in each state. The demonstration sizes vary between Tennessee's 1.2 million enrollees at the end of 1994 to Rhode Island's 70,000 at the end of 1995.

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[5]The only Medicaid eligible groups Tennessee excluded from the demonstration program were Qualified Medicare Beneficiaries, State Low Income Medicare Beneficiaries, and Qualified Disabled Working Individuals.

TABLE 1.2

KEY FEATURES OF THE FIVE DEMONSTRATIONS: POPULATIONS AND SERVICES IN THE FIRST YEAR

State	Program Name and Dates	New Demonstration Populations	Medicaid Populations Excluded from Demonstrations	Demonstration Services
Hawaii	QUEST Approval Date: 7/l 6/93 Start Date: 8/1/94	. Anticipated number of new enrollees: 5,000. About 31,000 individuals previously eligible for state programs (State Health Insurance Program and General Assistance) other than Medicaid now eligible for QUEST. . New eligibility categories and income limits: Through consolidation, QUEST is available to all uninsured people under 300 percent of poverty, except aged, blind and disabled. Current Aid to Families with Dependent Children-related medically needy program eliminated. . Assets test was reimposed in April 1996.	. Individuals in the Aged, Blind, and Disabled-related Supplemental Security Income (SSI) programs; Refugee Cash and Medical Assistance programs; and Medical Payments for Pensioners program.	. All medically necessary services covered prior to reform, except for long-term care, are covered by the demonstration (long term care is carved-out). . Enabling services, such as transportation and translation, are also included.
Maryland	Maryland Medicaid Section 1I 15 Health Care Reform Demonstration Approval Date: 10/30/96 Start Date: 1/2/97 (proposed)	. Anticipated number of new enrollees: None. . New eligibility categories and income limits: None.	. Dual eligibles, including qualified Medicare beneficiaries and specified low income Medicare beneficiaries; short-term eligibles in a "spend down" status; institutionalized individuals; children in the model waiver; individuals in the home and community-based services waiver for senior assisted housing residents; women in the family planning waiver program; and children in the Maryland Kids Count program.	. All services covered under Medicaid as of January 1, 1996, with some services carved out and paid for fee-for-service. These include: personal and medical day care services; services provide to children under an individualized education plan (IEP) or individual family service plan (IFSP); and transportation services. . All services will be provided through MCOs with the exception of specialty mental health services, which will be provided through a separate system administered by the Mental Hygiene Administration. MCOs will be financially responsible for self-referral by beneficiaries for: family planning services from alternative providers; school-based clinic set-vices; pregnancy related services; the initial medical exam for children under state custody; and annual visits to the Diagnostic and Evaluation Unit for individuals diagnosed with HIV/AIDS. . Individuals in the Rare and Expensive Case Management (RECM) program will receive extensive case management services in addition to all of the services provided under the demonstration.

TABLE 1.2 *(continued)*

State	Program Name and Dates	New Demonstration Populations	Medicaid Populations Excluded from Demonstrations	Demonstration Services
Oklahoma	SoonerCare Approval Date: 10/12/95 Start Date: 4/1/96	• Anticipated number of new enrollees: None. • New eligibility categories and income limits: None.	• Initially: long-term care recipients, people who are chronically mentally ill, and people in the medically needy spend-down group.	• Most services now covered under Medicaid, including mental-health and family-planning services, and additional wellness care. • Current service limits remain for people not under capitation.
Rhode Island	RIte Care Approval Date: 11/14/93 Start Date: 8/1/94	• Anticipated number of new enrollees: 10,000; number subsequently reduced • New eligibility groups and income limits: ▪ Pregnant women and children up to age 6 with family incomes below 250 percent of federal poverty level ▪ Extension of family-planning services for pregnant women 2 years after delivery ▪ Higher-income pregnant women and older siblings of eligible children may buy into RIte Care (at full cost to individuals).	• Individuals in the Aged, Blind, and Disabled-related SSI programs. • Individuals under age 19 for whom public agencies are assuming full or partial responsibility (that is, children in foster homes, private institutions, nursing facilities, or Intermediate Care Facilities for the Mentally Retarded (ICF-MRs).	• All services covered by Medicaid prior to reform except for long-term care services; residential treatment services; dental services; and some mental-health, mental retardation, and substance abuse services. These excluded services continue to be provided as "wrap-around" services on a fee-for-service basis. • Special capitation package for family-planning services only for 2 years after delivery for women who lose coverage 60 days postpartum.
Tennessee	TennCare Approval Date: 11/18193 Start Date: 1/1/94	• Anticipated number of new enrollees: 400,000. • New eligibility categories and income limits: ▪ All individuals who cannot obtain coverage due to preexisting conditions ▪ All uninsured, regardless of employment or income status, except if the person has access to health insurance ▪ Enrollment capped for newly entitled; not capped for Medicaid recipients ▪ Eligibility restricted to those uninsured prior to a date within the past year ▪ Eligibility period for medically needy program changed. All with sufficient medical expenses in 1 month to meet "spend-down" requirements qualify for TennCare for full year. Individuals no longer required to satisfy spend-down requirements every month. ▪ Eligibility for AFDC participants extended for 12 months	• Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, State Low-Income Medicare Beneficiaries.	• TennCare benefits package adds to medically necessary services provided under Medicaid. Eliminates service limitations, including 14-day limit on inpatient hospital stays. TennCare benefits package also covers dental care for individuals under age 21 and Early and Periodic Screening, Diagnosis, and Treatment services. • Demonstration excludes services such as long-term care, Medicare premiums, and 1915b waiver services. These services continue to be covered on a fee-for-service basis.

TABLE 1.3

KEY FEATURES OF THE FIVE DEMONSTRATIONS: MANAGED CARE, PAYMENT, AND FINANCING IN THE FIRST YEAR

State	Program Name and Dates	Managed Care	Cost-Sharing Requirements	Capitation and Provider Reimbursement	State Financing
Hawaii	QUEST Approval Date: 7/16/93 Start Date: 8/1/94	• Acute-care medical services provided by capitated medical plans (five managed care organizations--MCOs). Separate capitated dental plans (two MCOs) and behavioral-health plans for the seriously mentally ill (two MCOs). Long-term care services remain covered under the prior fee-for-service system. • Some state-funded reinsurance.	• Premium contributions required of individuals and families with incomes above 133 percent of federal poverty level. Contributions on a sliding scale of income. Pregnant women and children under age 19 with incomes below 185 percent of federal poverty level exempt from cost-sharing requirements. • Nominal copayments for those adults required to pay premmms. • Premium contributions increased in 1995 and 1996.	• All plans serving QUEST population paid on a capitated basis. Capitation rates differentiated by age, sex, eligibility category (for example Aid to Families with Dependent Children, General Assistance, or State Health Insurance Program), and region. • Separate capitation rates for dental services (separate from medical care) by two dental plans. Separate capitation rates being developed for managed mental-health care--mental health continues to be carved out. • State provides reinsurance to plans for costs incurred above $30,000 per QUEST enrollee, per year. • Physicians have range of risk-sharing arrangements (from capitated to discounted fee-for-service) with plans.	• Shifts SHIP and GA funds to QUEST. State savings due to federal matching. • Federal baseline increased through hypothetical 1902(r)(2) expansion. • Managed care savings anticipated. • Those above 133 percent of poverty have sliding scale for premiums and some cost sharing. • Disproportionate-share program eliminated as a separate payment.
Maryland	Maryland Medicaid Section 1115 Health Care Reform Demonstration Approval Date: 10/30/96 Start Date: 112197 (proposed)	• Acute-care medical services provided by capitated MCOs. Specialty mental health services will be provided and funded through a separate system administered by the mental hygiene administration (MHA). • The RECM component will consist of a network of specialized providers who are reimbursed on a fee-for-service basis to provide services for individuals (mostly children) who meet the defined criteria. • Long-term care not included in the demonstration.	• The demonstration will not involve the implementation of copayments, premiums, or deductibles.	• All MCOs paid on a capitated basis. • To preserve the safety-net providers, the state will assure that each historic provider (essentially any provider who has served the Medicaid Population prior to the implementation of the demonstration) who meets the standards established in the regulations, is offered a contract with at least one MCO. • Capitation rates will be risk adjusted to provide higher payment levels for high cost patients (populations with special needs). A sophisticated nsk adjustment system is being developed by the University of Maryland and Johns Hopkms Health Services Research and Demonstration Center and Actuarial Research Corporation.	• Federal baseline assumed to remain the same for the demonstration population as it currently is under the fee-for-service Medicaid program. • Managed care savings. anticipated; savmgs will accrue to state and federal government.

TABLE I.3 *(continued)*

State	Program Name and Dates	Managed Care	Cost-Sharing Requirements	Capitation and Provider Reimbursement	State Financing
Maryland *(continued)*				• There is a stoploss limit of $50,000 in inpatient hospital expenditures per enrollee in a calendar year and a program for managing MCO enrollees who reach the limit.	
Oklahoma	SoonerCare Approval Date: 10/12/95 Start Date: 4/1/96	• Extension of mandatory managed care in three metropolitan areas under a 1915(b) waiver to all areas of the state. • MCOs in three metropolitan areas must qualify as rural partners by enrolling a specified number of rural beneficiaries in surrounding counties. • Primary care case management will be implemented in the rural areas not included in the rural partners areas. Starting in July 1997 new rural models will be encouraged (such as full and partial capitation models).	• In the urban/metropolitan MCO component of the program, there are no copayments. In the rural primary care case management component, services that are not in the capitation package may be subject to nominal copayments for example, $1 copayment for prescription drugs (these apply to fee-for-service benefits).	• Capitation rates will vary by age, sex, and possibly health status. MCOs will bid on the rates, while primary care case managers must accept the established rate. • Primary care case managers will be capitated for primary care services, basic ancillary services, and most referrals. • Outpatient networks will be capitated for all or most outpatient services. • Fully capitated MCOs will be paid a rate for a full range of inpatient and outpatient care.	• No additional financing, since eligibility is not being expanded.
Rhode Island	Rite Care Approval Date: 11/14/93 Start Date: 8/1/94	• All enrollees (except those excluded from demonstration) required to enroll in one of five prepaid, capitated health plans that contract with state to provide package of benefits. • Community health centers have formed their own health plan, which was licensed 4 months after the demonstration began.	• Pregnant women and infants with family incomes below 185 percent of federal poverty level and children ages 1 to 5 years with family incomes below 133 percent of the federal poverty level are not required to contribute. • Individuals and families with incomes above 185 percent of federal poverty level elect premium cost sharing or point of service cost sharing. • Premium cost sharing requires individuals to pay monthly premiums based on a percentage of actual capitation rate charged by plan. Percentage of premium paid based on sliding scale of income. • Point of service cost sharing requires no premrum contributions, but does require copayments.	• Capitation amounts vary by eight different age-sex categories. All plans paid on a capitated basis. Rates do not vary by region, • FQHCs receive supplemental capitation payment of $10 per member, per month for each person selecting the FQHC as a primary care provider. • Special capitation rate for extended family-planning services (offered to women who remain eligible 2 years after delivery). • State offers optional reinsurance program to limit health plans' risk. Health plans may choose level and type of reinsurance. • Physician reimbursement method varies by plan.	• Savings from increased use of managed care in Medicaid. • Copayments or premium contributions from people in the expansion groups.

TABLE 1.3 (Continued)

State	Program Name and Dates	Managed Care	Cost-Sharing Requirements	Capitation and Provider Reimbursement	State Financing
Tennessee	TennCare Approval Date: 11/18/93 Start Date: 1/1/94	• Both the current Medicaid population--including the aged, blind, and disabled--and the newly entitled enrolled in 12 MCOs that contract with the state on a capitated basis to provide all medically necessary services except long term care, which remains covered on a fee-for-service basis. • About half of MCOs are HMOs and half are PPOs. • HMOs are at risk for costs of services, while PPOs, by law, are not at risk.	• TennCare participants with incomes at or below 100 percent of federal poverty level or Medicaid-eligible are not subject to cost sharing. • For TennCare participants with incomes between 101 and 400 percent of federal poverty level, cost sharing includes premium contributions, copayments, and deductibles, which vary by income level. • At or above 400 percent of the federal poverty level, full cost sharing through premiums, copay requirements, and deductibles.	• All MCOs paid on a capitated basis for TennCare benefit package. Capitated rates for these services adjusted for age, sex (during childbearing years only), and disability status. Rates do not vary by region. • State carves out mental health services for the seriously mentally ill and reimburses providers on a fee-for-service basis. • Each MCO negotiates payment methods with providers. • Pool for MCOs serving beneficiaries with high cost chronic conditions. • Payments made to MCOs for the first 30 days of service for the uninsured and uninsurable enrollees in the first year.	• Savings from increased use of managed care. Disproportionate-share funds transferred to subsidize premiums for newly eligible. • Premium payments, deductibles, and copayments for those with family income over 100 percent of federal poverty level and not meeting Medicaid criteria. • Existing local government contributions for indigent care. • Savings from reductions in public health programs. • Charity care contributions from providers. • New state revenues.

C. OVERVIEW OF THE EVALUATION

1. Purpose of the Evaluation

The state reforms represent a major shift in the way health care for the poor is financed and delivered. Consequently, the demonstrations raise many important policy questions regarding access to care and the quality of care provided under managed care arrangements, as well as the structure of the health care delivery system. Furthermore, important lessons can be learned from how these demonstrations are implemented and financed and the programs' ability to control costs and maintain quality.

a. Implementation Evaluation

In our evaluation, the analysis of program implementation and organization will document the five demonstrations as they evolve from initial implementation, through program refinement, to program maturity. A comprehensive assessment of the implementation, structure, and operations of the demonstrations will provide insights into which aspects of the demonstration programs result in successful reforms. Our evaluation will look at program design, organization and implementation, eligibility and enrollment, financing, quality, MCO and provider contracting, and provider participation and reimbursement. Furthermore, we will document how all of these aspects change over time after initial implementation. Table I.4 lists the questions. In Chapter II, we discuss methodology and data sources for the analysis of implementation and organization.

Program design and program implementation have required changes in the relationships among state agencies, as well as restructuring of some agencies. Furthermore, the demonstrations have required the states to change from managing their Medicaid programs to contracting with and monitoring MCOs, creating new responsibilities and new opportunities (such as setting standards for and monitoring the MCOs' performance). As Table I.4 shows, we will document state agency organizational linkages and changes, as well as contractual arrangements between the states and the MCOs.

TABLE I.4

ORGANIZATIONAL EVALUATION: RESEARCH QUESTIONS AND TECHNICAL APPROACH

Research Issues	Technical Approach to Evaluation
Program Organization and Implementation Issues	
How were demonstrations implemented, and how did they change? What factors helped or hindered implementation? How did state and local officials, providers, advocates, and clients feel about the demonstrations? What types of organizational linkages developed? How well did these work? What data systems are available? How was the state monitoring quality of care?	Site visit interviews with state officials and other stakeholders (such as industry representatives, advocates, legislators, health care providers, and local eligibility staff) will assess implementation strategies and their success. Continuing monitoring will be conducted to keep abreast of policy changes and problems encountered. Document review will show implementation plans and organizational linkages. Focus groups with clients and potential clients will examine their experiences with the system changes and their perceptions of the demonstration. Focus groups with providers will evaluate their experience with the demonstration and assess their relationship with the managed care organizations (MCOs).
Eligibility and Enrollment Issues	
What changes were made in eligibility and enrollment systems? How were these coordinated with programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children or Maternal and Child Health programs? Were those with special needs targeted? Did newly eligible people enroll in demonstration projects? Did those with high assets join? How did factors such as health status, income, assets, and family composition affect enrollment? What safeguards existed to discourage employers from dropping insurance? Did these work well? Did enrollees switch health care providers on voluntary/involuntary basis? How did this affect their health services? How did changes affect provider payment?	Site visit interviews and review of state documents will be used to examine basic changes in eligibility rules and enrollment systems. Interviews will include local eligibility and provider information staff. State data (if available) will be examined for trends in enrollment. Analyses of postimplementation surveys of low-income people will be used to examine the participation of previously and newly eligible people and factors affecting participation. Trend analyses of CPS/TRIM2 files will be used to examine state-specific changes in insurance levels, including changes in employer-based insurance. Focus groups of low-income and disabled people will be used to obtain insights into factors affecting program participation and program use, including their selection of health care providers.
Financing Issues	
How did states finance the demonstrations? Was funding drawn from other health or welfare programs? How did actual budgeting compare with planned budgeting'?	Budget documents will be analyzed for planning and actual experience. Site visit interviews will be conducted with state and local staff, including budget staff and staff of other public health programs. Other state funding and revenue data (for example, National Association of State Budget Officers data) will be analyzed.

TABLE I.4 *(continued)*

Research Issues	Technical Approach
Managed Care System Issues	
How did managed care systems respond to the demonstrations? To what extent were new organizations formed? How did existing MCOs change service areas or otherwise restructure? How did the states develop capitated (or other managed care) payment rates? Were the payment rates adequate? How do they differ from old rates? How did MCOs structure their internal operations and payment mechanisms? How were special-needs populations accommodated in managed care (for example, different systems, risk adjustments. exclusions)?	Document review, done on a comparative basis within and across states, will examine contractual and organizational relationships, as well as systems for developing, selecting, and monitoring MCOs, setting payment rates, and monitoring quality of care. Site visit interviews will focus on managed care (and other provider issues) at state level, as well as in urban and rural health care market areas. We will examine key implementation issues and also interview quality assurance organizations related to these. We will review financial data from managed care providers. We will compare trends in demonstration states to others, using data such as Medicaid managed care enrollment reports and Group Health Association of America data. Focus groups with urban, rural, and disabled clients will examine their experiences with and perceptions of the MCOs. Focus groups with providers will examine their reaction to managed care under the demonstrations.
Provider Participation Issues	
Was there an adequate level of physician participation. especially by primary care medical doctors? Were there enough providers in rural or inner-city areas? Are there providers of culturally sensitive services? Did their volume or pattern of care change due to the demonstrations? How were providers who traditionally served the poor (for example, public or teaching hospitals, Federally Qualified Health Centers, rural clinics, or family planning clinics) involved? How did the demonstrations affect their caseloads or finances?	If available, we will review provider participation data to examine changes in physician participation by geographic area (such as by county or zip code). An optional alternative for one or more states is a telephone or mail sample survey of physicians to collect more systematic information on physician participation in the demonstration. Site visit interviews will be conducted with representatives of provider organizations at state capital level. Interviews will also be conducted at urban and rural market levels, including interviews with hospital and clinic staff physicians, and advocates. Systems for paying these providers, within or outside of the managed care networks, will be reviewed. Special attention will be given to issues of disproportionate-share funding.
Data Issues	
Are state-based data (which include procedural manuals, claims/encounter data, state reports, and managed care data) adequate for the organizational or impact evaluations? Do we need to make other adjustments in research plans or consider alternative modes of data collection?	Case studies will begin assessment of data systems as they relate to encounter data that will later be needed. Site visit interviews with relevant state and MCO officials will be done to discuss their data sets, procedures for validation, and availability. We will also collect and assess samples of data and data documentation. We will work with the state to ensure that we can be on the routine distribution list for reports and important correspondence.

The Medicaid eligibility process has historically been criticized for delays of weeks or months between application and enrollment, as well as for the time, stigma, and effort associated with going to the welfare office to apply for Medicaid. We will assess the demonstration programs' eligibility and enrollment processes in light of the new features intended to improve the process: streamlined eligibility, dropping of the assets test, and greatly expanded eligibility. We will assess how smoothly the population was enrolled in managed care and document the process. We also will assess how the states define and process Medicaid-eligible and demonstration-only-eligible program participants. Finally, we will document which populations are enrolled in managed care and whether the experiences of the disabled, aged, and blind population (if enrolled) differ from those of other groups.

The states are all hoping to control their costs through these demonstrations; cost control is one of the main reasons for applying for a demonstration. To finance the demonstrations, some states have used Medicaid funds that would have been allocated if they had implemented a 1902(r)(2) provision through their state plan, from their disproportionate-share programs, other state health programs, and participant premiums.[6] We will examine how states funded their programs and compare demonstration spending with the projected spending.

Integral to each demonstration is the effort to shift a large part or all of the Medicaid population from fee-for-service health care coverage into managed care. The states hope to provide a "medical home" for their beneficiaries, through use of primary care gatekeepers, thus improving access to and quality of care and (at the same time) controlling costs. We will document the managed care arrangements in the demonstrations, which range from primary care case management, proposed in the rural areas of Oklahoma, to fully capitated managed care through Health Maintenance Organizations (HMOs). We also will document the capitation payment methods that the states use, the basis for developing the initial rate, and any rate changes that occur during the demonstration. We anticipate that the numbers and types of

[6]Hawaii and Rhode Island included hypothetical 1902(r)(2) funding in their assumed costs of Medicaid without the waiver program.

MCOs may change within states over the course of the demonstration and will document these trends and the reasons for them. Finally, we will document a critical aspect of managed care: the development and maintenance of adequate and effective networks of providers by the MCOs and changes in these networks over time. Provider payment methods are an integral part of this assessment, as is whether providers actually participate in providing care to demonstration beneficiaries. We also will assess the impact of the move to managed care on the safety net providers in each state.

b. Impact Evaluation

By introducing managed care and expanding coverage to previously uninsured low-income families, the demonstrations potentially will affect individuals' health status and outcomes. Therefore, our evaluation will measure the effects of managed care and the expansions of coverage on beneficiary access and satisfaction, and on the quality, number, and types of service used. We also hope to assess whether insuring the expansion group improved their health **status.** Table I.5 outlines the key questions we plan to evaluate.

By extending coverage under the Medicaid program to the poor and near poor, three of the demonstrations aim to increase access to health care for the previously uninsured group. We will assess the effect of the demonstrations on the number of uninsured people in the states and describe the characteristics of the people who actually enrolled in the expansion groups. The reliance on managed care in the demonstrations also may have implications for access. For the Medicaid-eligible group, the demonstrations may change access locations through **use** of primary care gatekeepers; we will assess whether this improves or reduces access to primary and other care. We also will assess differential effects for some of the most vuinerable groups, **such** as mentally ill, substance abusing, and disabled people (when covered by the demonstration).

Similarly, we will assess the impacts of the demonstrations on quality of care provided. Managed care has the potential to improve quality of care through increased provision of preventive services and greater

TABLE I.5

IMPACT EVALUATION: RESEARCH QUESTIONS AND TECHNICAL APPROACH

Questions	Illustrative Measures	Data Sources	Analytic Techniques
Managed Care Impacts			
Access			
What is the impact of managed care on access to health care?	Percentage of beneficiaries with a physician visit in the past year	Claims and encounter data	Regression-adjusted difference between Medicaid-eligible participants before and during the demonstration
What was the effect on access of the use of primary care gatekeepers?	Number of visits to physicians		
	Number of hospital admissions for preventable illnesses		
	Use of preventive services		
Continuity of Care			
Does managed care affect continuity of care?	Percentage of primary care visits to the same provider	Claims and encounter data	Regression-adjusted difference between Medicaid-eligible participants before and during the demonstration
	Number of emergency room visits for primary care and management of chronic conditions		
Quality of Care			
How did managed care impact on quality of care?	Timing of hospital admissions, hospital readmission rates	Claims and encounter data	Regression-adjusted difference between Medicaid-eligible participants before and during the demonstration
	Use of preventive services, such as immunizations, prenatal care, pap smears, mammograms		
	Birth weight and neonatal complications		
Satisfaction			
Were patients satisfied with care, costs, access under managed care?	Overall satisfaction	Household survey	Descriptive analysis
	Satisfaction with specific aspects of care, such as provider networks, out-of-pocket costs		

TABLE *I.5 (continued)*

Questions	Illustrative Measures	Data Sources	Analytic Techniques
Utilization			
What is the impact of managed care on utilization ?	Number of primary care visits Number of physician office visits Number of physician visits to specialists Number of hospital admissions Average length of hospital stay Number of emergency room visits for primary care Number of preventive care services	Claims and encounter data	Regression-adjusted difference between Medicaid eligible participants before and during the demonstration
Expansion Group Impacts			
Access			
What is the impact of expanding Medicaid coverage on access to the delivery system?	Use of preventive services Hours care open, waiting times, time spent with provider, access to specialists, hospital care, out-of-pocket costs of care, etc.	Household survey	Regression-adjusted difference between expansion group and comparison group
What is the impact of changes in eligibility procedures on access?	Perceived barriers to enrollment		
Does participation improve access to care, cost?	Travel time Out-of-pocket costs		
What is the impact on reducing barriers to access?	Reasons for not obtaining care		
Continuity of Care			
Does health insurance improve continuity of care?	Changes in usual source of care Emergency room visits for primary care and treatment of chronic conditions Multiple prescriptions by more than one provider	Household survey	Regression-adjusted difference between expansion group and comparison group

TABLE *I.5 (continued)*

Questions	Illustrative Mcasurcs	Data Sources	Analytic Techniques
Quality of Care			
Did the use of preventive services increase under the demonstration?	Use of preventive services	Household survey	Regression-adjusted difference between expansion group and comparison group
Did health status improve?	Rirthweight		
	Health status		
	Restricted activity days		
Satisfaction			
Were members of the expansion group more satisfied with their health care?	Overall satisfaction	Household survey	Regression-adjusted difference between expansion group and comparison group
What aspects of care were members of the expansion group most satistied with?	Specific measures such as out-of-pocket costs, covered services, convenience of location of care, travel time to source of care		
Utilization			
What was the impact of the expansions on utilization?	Number of preventive services such as EPSDT and well child visits	Household survey	Regression-adjusted difference between expansion group and comparison group
	Number of physician visits (primary and specialty)		
	Number of emergency room visits for primary care		
	Whether admitted to a hospital		

continuity of care. However, managed care has some financial incentives to limit the amount of care provided, and this could have the opposite effect on quality. We will look for identifiable impacts on preventable hospitalizations, timing of hospital admissions, readmissions, use of preventive services, immunizations, and continuity of care. Impacts on quality may also be measurable through consumer satisfaction, which we will assess.

Our analysis of service use and costs will assess whether managed care and expansion of eligibility achieve the policy objectives of delivering more cost-effective care and encouraging use of preventive and primary care services. We will estimate use of these services and then develop a summary measure of health resources saved by the move to managed care. We also will assess whether there are differential effects for different types of managed care plans.

Finally, we will estimate what the Medicaid and total health expenditures would have been without the demonstration. The waivers require the demonstrations to be budget neutral to the federal government, but each of the states hopes to spend less than it otherwise would have through using managed care. We will determine the best assumptions for enrollment and cost growth with and without the demonstrations.

This major impact evaluation of five demonstration programs depends on a formal design supported by extensive data collection and analysis. As described in Brown et al. (1995), the evaluation will assess impacts by making formal comparisons of a treatment group with a comparison group representing "what would have happened to the treatment group without the demonstration." To measure the impacts of managed care, we will compare the experiences of the treatment group of Medicaid-eligible participants during the demonstration with those of Medicaid participants before the demonstration. This analysis will draw on Medicaid claims data from the earlier period and encounter data generated by the MCOs during the demonstration. The evaluation also will also assess the impacts of the demonstrations on the expansion group of newly insured individuals. To measure the impacts of the expansion on the treatment group of newly insured people, we will compare them with near-eligible and eligible nonenrolled people. This

analysis will draw on surveys (to take place durin g 1997 and 1998) of newly eligible people and comparable nonparticipants.

2. Data Collection for the Impact Analysis

The impact evaluation depends on two key databases: (1) claims and encounter data from the states, and (2) household data from a telephone survey that we will conduct. This section briefly reviews issues in data collection identified in the first year of the project that could affect the evaluation.

a. Claims and Encounter Data Collection

The claims and encounter data will be used to assess the managed care impacts of the demonstrations. One issue that this report discusses is the difficulties states are experiencing getting their management information systems into shape to monitor managed care. They have had difficulties with their eligibility systems because of the new information that these systems need to include (MCO identity and enrollment dates), and there are many unknowns concerning the completeness and accuracy of the encounter data (provider, MCO, and state ability to produce). By early 1997, we expect to receive 1994 and 1995 encounter data for Tennessee, Hawaii, and Rhode Island. Before we attempt to build analysis files, we will conduct face validity checks on these data and assess internal consistency.

In addition, Rhode Island's data present a unique problem. Rhode Island had little predemonstration experience with a certified Medicaid Management Information System (it was implemented at the end of 1993, the year before the demonstration was implemented). Thus, in Rhode Island, the predemonstration period available for comparison with the demonstration period was that just before the demonstration. Moreover, for some enrollees the period is very short (no more than 7 months). However, because Rhode Island enrolled its demonstration population into managed care over a 1-year period, we will have a full year of predemonstration claims data for some enrollees enrolled after January 1995. We are just

beginning our analysis of data in Oklahoma and cannot yet assess how good their data will be. Since Maryland's program has not yet begun, we will have to wait to evaluate the quality of their data.

b. Survey Data Collection

The analysis of the impacts of the demonstration on the expansion group depends on survey data to compare an expansion group with a comparison group. The consumer focus group discussions during the first year have helped to focus the instrument design. The instrument will cover satisfaction with different aspects of the MCO and provider, measures of access such as travel time, having a usual source of care and access to specialists, and measures of use of preventive services and continuity of care. It will also cover prior insurance coverage, current and recent pregnancies, health risk behaviors, and demographics. We originally planned to conduct the telephone survey in two waves: one in 1996 and another in 1998. Because of the lack of expansion groups in Rhode Island and Oklahoma, we are now rethinking this design. We may conduct only one survey wave in these two states; this survey wave could be used to collect descriptive data of policy interest on enrollees' access, satisfaction, and service use. A supplemental survey of disabled enrollees in TennCare will also be conducted to find out more about this group's access to care and the characteristics of that care.

The survey instrument was pretested during 1996, and the first survey wave will be fielded as soon as OMB Clearance is secured. The survey will include 14,000 families across all five states.

3. Future Analysis Plans

This section summarizes our evaluation plans for the rest of the contract and draws on information obtained in the first 18 months of the project to suggest slight modifications to the evaluation design.

a. Implementation Evaluation

This first implementation report on the three states (Tennessee, Hawaii, and Rhode Island), that implemented their programs in 1994, describes the demonstrations' designs, how they were implemented,

and the administrative changes that the states have made or planned to improve their programs.[7] During 1997, we will assess these same issues for Oklahoma (which started its program in 1996) and Maryland (which will start its program in 1997).

For Tennessee, Hawaii, and Rhode Island, we plan follow-up visits during 1996. These visits will include a review of selected topics identified in this report. In all three states we will look at the following issues:

- Changes in the enrollee population and the state's uninsured population due to economic conditions and policy changes (for example, welfare reform)
- Changes in budget patterns for the projects, including changes in revenue sources or expenditures and changes made because of budget problems during the first year
- The state's monitoring of the MCOs, especially quality improvement/quality assurance monitoring, and the findings of this monitoring (including the results of special studies using medical records, network adequacy studies, and patient satisfaction surveys)
- Changes in the capitation rates and in the willingness of MCOs to serve the waiver programs (more or fewer MCOs)
- Changes in the health care market, including closure of major providers and willingness of providers to continue participating
- Continued impacts of managed care on safety net providers
- Ongoing eligibility and systems issues such as enrollee turnover, plan enrollment, enrollment of newborns, external verification of eligibility, and coverage during the time between applying for and receiving MCO membership card
- Welfare reform initiatives

In Tennessee a number of issues deserve special attention. We will look closely at TennCare funding to assess whether the state is able to collect and expend the amounts it budgeted and thus draw down all of the approved federal funding. Related to the funding issue in Tennessee is the state's policy toward the

[7]Each state received a draft copy of this first annual report, and had the opportunity to comment on it.

expansion group of uninsured people: will it have sufficient funding to reopen the group to new enrollment? What is the future of this expansion group? Tennessee's new coverage of mental health care for the severely and persistently mentally ill and its continuing coverage of the disabled population also merit additional attention. Therefore, we will also focus on the implementation of the capitated program for the population of severely and persistently mentally ill members of TennCare (as of July 1, 1996). We also will begin a special study of the disabled population, which will include meeting with disability experts and advocates in the state and elaborating the processes through which disabled TennCare participants are enrolled in an MCO, are assigned to primary care gatekeepers, and get access to specialty care.[8]

In Hawaii, we will review the state's efforts to limit QUEST participation levels to stay within budget. The state options include tightening eligibility criteria, further increasing premiums, or reducing the benefit package.

In Rhode Island, we will be keeping a close watch on the financial viability of the Federally Qualified Health Centers in the state. We will also track the state's attempts to increase enrollment in the expansion groups. Finally, we will monitor several policy changes being planned for RIte Care in the second year to see if these design modifications work. For example, will MCOs, providers, and advocates be satisfied with the new procedures for accessing emergency services and nonmedical social services? Will the program and eligibility determination process become more responsive to the needs of the non-English-speaking population in RIte Care? Will the new definition of medical necessity resolve some of the concerns about limits on mental health services'?

We will report on these implementation studies in the second annual report. That report will also include initial impact studies, as discussed next.

'This work is in the planning stages.

b. Impact Evaluation

As described earlier, we will assess two types of demonstration impacts: (1) that of managed care on the "Medicaid-eligible" groups, and (2) that of the program expansions on the newly covered groups. These two analyses depend on different data sources. The managed care impact analysis will use Medicaid claims and encounter data, which we hope to have available during the coming months. The expansion impact analysis will use survey data, which will not be collected until 1997 and which will not be available in time to complete the analysis in the second year of the evaluation. Therefore, this part of the impact analysis will not be included in the next annual report.

During 1997, we plan to conduct an analysis of the impacts of managed care on access, quality, and service use during the first demonstration year for those states that implemented their programs early enough for us to have any data (Tennessee, Hawaii, and Rhode Island). This analysis will compare outcomes among Medicaid enrollees in the period before the programs began with outcomes among a comparable group of Medicaid-eligible enrollees in the year after the programs began. To conduct this analysis, we will use claims data from the predemonstration period and both claims and encounter data for the demonstration period. As we discussed in the section on data, our ability to do this analysis is contingent on receiving predemonstration claims data and demonstration encounter data of adequate quality, which we are still in the process of collecting and assessing.

A question this report has raised is exactly how many uninsured people exist and what their characteristics are. Hawaii appears to have underestimated the number of people eligible for its program. Tennessee enrolled many people who may not have been eligible but who nevertheless had no insurance. In contrast, Rhode Island appears to have overestimated the uninsured eligible population. The screening portion of the household survey we will conduct in 1997 will provide some estimates of the number of uninsured people and their characteristics; we plan to present these estimates in the next annual report.

The characteristics of the demonstrations will lead us to deviate a little from the overall evaluation design (see Brown et al. 1995). Oklahoma has no expansion group but will have two different models of

managed care in different parts of the state. Maryland has no expansion group. Rhode Island has an expansion group of less than 1,000 people, which makes a comparison with a group of nonenrolled but similar people very difficult to implement. For these three states, we will focus only on managed care impacts.

c. Summary of Future Reports

There will be three more annual reports, followed by a final report. Table I.6 lists the content and timing of the future evaluation reports.

D. ORGANIZATION OF THE REPORT

Chapter II describes the methods we used to collect and analyze data on demonstration implementation in the three states: Rhode Island, Hawaii, and Tennessee. Chapters III through V look at demonstration design and implementation in the three states. Chapters III, IV and V examine the first 12 months of Rhode Island's and Hawaii's programs, and the first 18 months of Tennessee's program, respectively. These three chapters describe the reasons states applied for their waivers, the process by which they designed and implemented their waiver programs, details of the design, and problems encountered and lessons learned, all from the perspectives of the state, providers, consumers, and HCFA.

The states have had many common experiences as well as differences, and Chapter VI synthesizes states' experiences. The chapter compares and contrasts the design and implementation structure and process across the three states. It highlights features common to all three states and identifies unique features (some of which may be replicable, and some of which other states may wish to avoid).

Table I.7 presents the key technical terms we use throughout the report, with definitions and abbreviations.

TABLE I.6

SIJMMARY OF ANALYSES TO BE INCLUDED IN FUTURE EVALUATION REPORTS

Type of Analysis	Second Annual Report	Third Annual Report	Fourth Annual Report	Final Report
Implementation Analysis				
Oklahoma and Maryland		Describe design, planning, and initial implementation Describe eligibility changes and enrollment under the waiver What are the characteristics of new enrollees? What are the financing sources? What types of managed care are used? How are MCOs selected and contracted with? What are consumer views on quality of care? What are provider views on participating?	Describe procedural, organizational, and design changes Describe changes in enrollment and disenrollment, and trends in the uninsured What changes are the MCOs going through? Did capitation rates change? What are the spending trends? What are the quality improvement procedures, and how well do they work? Is physician participation adequate? What is happening to safety net providers?	How did the programs evolve over time? Why? With what impacts? What were the overall trends in enrollment, and how did they affect the level of the uninsured? How did the original budget estimates correspond with actual expenditures? How did the states and MCOs implement and then modify managed care? Did services and quality change? Did the demonstration program affect access to services?
Tennessee. Hawaii, and Rhode island	Describe procedural, organizational, and design changes Describe changes in enrollment and disenrollment, and trends in the uninsured What changes are the MCOs going through? Did capitation rates change? What are the spending trends? What are the quality improvement procedures, and how well do they work? Is physician participation adequate? What is happening to safety net providers?	Same as second report, with any new issues covered	Same as the third report, with new issues also covered	Same as Maryland and Oklahoma
Expenditure Analysis				
	Assess first and second demonstration year federal and state Medicaid costs Describe total state-level health care spending in 1993	Assess Medicaid outlays between 1993 and 1996 Describe out-of-pocket beneficiary expenses	Assess Medicaid outlays between 1993and 1997 Describe total state-level health care spending in 1995	Summarize cost implications of the demonstrations for 1993 to 1997 Describe out-of pocket expenses Describe total state-level health care spending in 1997

TABLE 1.6 *(continued)*

Type of Analysis	Second Annual Report	Third Annual Report	Fourth Annual Report	Final Report
		Impact Analysis		
All States	No data available.	What were the managed care impacts on quality of care, access to care, satisfaction with care, and use of care (in the first and second year of the demonstrations)? What were the impacts of the program expansions on quality of care, access to care, satisfaction with care, use of care, and health status?	What were the managed care impacts on quality of care, access to care, satisfaction with care, and use of care (in the third year of the demonstrations)?	Did the demonstration improve quality of care, access to care, satisfaction with care, and use of care? Managed care impacts in Years 1 to 4 Expansion impacts in Years 2 and 4

TABLE I. 7

GLOSSARY OF COMMON TERMS AND ABBREVIATIONS USED IN THIS REPORT

Section 1115 demonstration	A research and demonstration project that permits state Medicaid programs to make numerous changes in program design for a limited period of time. Similar Section 1115 demonstration projects may also be developed for welfare reform.
Section 1902(r)(2)	A Medicaid eligibility option that states may use to modify income or asset eligibility rules for pregnant women, children, and some other groups.
Auto-assignment	A process used to assign Medicaid enrollees to a managed care organization when they have not selected a plan on their own or when the plan they chose is not taking more members.
Budget neutrality	For Section 1115 demonstrations, this term means that the new program does not require more federal funds than the preexisting program during the demonstration period, based on a number of budgetary assumptions. The federal government has established two main types of budget neutrality rules: (1) *aggregate limits,* in which total federal funds are capped at predetermined dollar levels, and (2) *per capita limits,* in which federal payments are capped based on the number of Medicaid enrollees served before the demonstration and a baseline rate times a predetermined inflation factor.
Capitated	Medical services are paid for based on a set monthly amount per person, instead of on a fee-for-service basis. Capitation may occur at a plan or provider level. If a plan is capitated, then the state makes a.predetermined payment per person for medical services. If a physician or provider is capitated, then the managed care plan pays him or her a set amount per person for certain services.
Carve-out	A set of services or patients excluded from a managed care plan. For example, a carve-out behavioral-health plan means that certain mental-health services are not covered by the main medical plan, but by another plan specializing in behavioral-health services.
Federally Qualified Health Center (FQHC)	A subset of community health centers or similar organizations that meet Federal standards, as set forth in the Public Health Service Act, and receive enhanced Medicaid payments, based on the actual costs of providing care.
Group Model HMO	An organized prepaid health care system that contracts with one independent group practice to provide health services (Group Health Association of America, 1995).

TABLE I.7 *(continued)*

Health Maintenance Organization (HMO)	An organization that provides comprehensive medical services and that is paid on a capitated (prepaid) basis. Members must receive care from a limited panel of health care providers. HMOs usually require members to have a primary care provider.
Independent Practice Association (IPA)	An organized, prepaid health care system that contracts directly with physicians in independent practice, and/or with one or more multispecialty group practices (but predominantly organized around solo/single specialty practices) to provide heath services (Group Health Association of America 1995).
Managed Care Organization (MCO)	A general term for insurance plans or HMOs that contract with the state to provide managed care for Medicaid enrollees.
Medicaid Management Information System (MMIS)	The automated data system used for Medicaid, which includes subsystems for claims, providers, and eligibility records.
Preferred Provider Organization (PPO)	In the commercial realm, this is a type of insurance plan in which members may receive services for a nominal copayment from a limited list of providers but may also get care from providers not on the list by paying higher copayments or deductibles. In TennCare, this means an organization that receives a capitated payment and has a limited list of providers, but primary care gatekeeping is not required. (TennCare PPOs will convert to HMOs later.)
Primary care provider (PCP)	Also called a ***gatekeeper.*** This is the physician or other provider who has main responsibility for medical care for a patient. Primary care providers must approve most specialty care, diagnostic testing, or hospital care for their patients. Primary care providers are usually family or general practitioners, internists, or pediatricians (sometimes obstetricians). Physician assistants and nurse practitioners may also be primary care providers.
Reinsurance	A secondary level of insurance, used to reduce financial risk for the main insurer. Typically, a reinsurer pays for patients whose medical expenses exceed a set level, (for example, $30,000 to $100,000 per year).
Staff Model HMO	An organized prepaid health care system that delivers health services through salaried physician groups that are employed by the HMO unit (Group Health Association of America, 1995).

II. METHODOLOGY

The far-reaching changes the demonstrations adopted required major new administrative initiatives and considerable interagency coordination. The major focus of year 1 of the evaluation was to document and assess specific organizational and implementation elements and their relative contributions to the programs' effectiveness. We examined the structural linkages among the parties (states, managed care organizations (MCOs), and providers) involved in implementation, as well as administrative systems that developed under the demonstrations, using case study methodology. In this chapter, we describe in detail the three main elements of the case study approach (site visits, focus groups, and offsite monitoring), as well as document review.

A. SITE VISITS

The principal source of information for this report was the first-year site visit interviews, which aimed at understanding issues arising during the initial phase of the demonstrations.' Following standard case study methodology, we developed semistructured interview protocols, trained site visit staff, and convened debriefing meetings after each site visit (Nightingale and Rossman 1994).

The first-year site visits consisted of two separate 1 -week visits, during which we visited the state capital, an urban health care market, and a rural health care market (see Table II. 1). Site visit teams were made up of two or three researchers. Rural areas were selected on the basis of advice from state sources, data about county-level poverty and physician-to-population levels, and data about health care facilities, such as community health centers.

'Site visits to examine the two other critical phases of the demonstrations, program refinement and program maturity, are scheduled for Year 2 and Year 4 of the study.

1. Site Visit Schedule

Given the varied implementation schedules of the three demonstrations, the site visits occurred at different times relative to when states implemented the reforms (see Table II. 1). For instance, the first trip in Tennessee was made in May 1995, 16 months after TennCare was implemented. The Hawaii and Rhode Island site visit teams each made their first trip about 9 months after their respective demonstrations had started.

2. Key Respondents

The first round of site visits focused primarily on the state capital, in which researchers interviewed a range of individuals representing the major stakeholders in the demonstrations to fully document the organizational linkages, contractual arrangements and monitoring processes that developed in each state. With some tailoring in each state, respondents included:

- Medicaid/demonstration program staff
  - Program director and/or department director
  - Managed care staff
  - Budget and data analysis staff
  - Eligibility staff
  - Quality assurance staff
- Other key state staff
  - Public health officials
  - Insurance or finance department officials
- State legislators
- Provider organization representatives
  - State medical association
  - State hospital association
  - State primary care association
  - Other specialty associations

TABLE II. 1

SITE VISIT DATES AND LOCATIONS

	Tennessee		Hawaii		Rhode Island	
	May 1995	June 1995	April 1995	May 1995	May 1995	August 1995
Locations	Chattanooga; Nashville	Urban Market Area: Memphis Rural Market Area: Fayette County	Honolulu	Urban Market Area: Honolulu Rural Market Area: West side of the Big Island	Cranston; Providence	Urban Market Area: Providence Rural Market Area: Southern part of Washington County

- Managed care organizations
  - Demonstration program directors
  - Medical directors
  - Enrollment staff
  - Quality assurance staff
  - Financial staff
- Advocacy group representatives

The second round of site visits concentrated on the implementation process in the urban and rural health care case study markets. In Tennessee, researchers met with additional MCOs during the second site visit. Typically, we met with the following types of stakeholders at the local level in urban and rural health care markets:

- Hospitals
  - Representative of community hospitals in urban and rural areas
- Physicians
  - Rural physicians (urban physicians participated in a focus group)
- Community health center staff
- Local eligibility and enrollment staff

B. FOCUS GROUPS

To provide insight into consumers' and providers' experiences with the programs and the underlying reasons for their reactions, we held a series of focus groups in each state. The focus groups were small in size, and participants were not randomly sampled. As a result, the focus groups do not provide firm quantitative estimates of the reactions of consumers and physicians, but they do offer important insights into the grass-roots effects of the new demonstration programs.

We conducted four focus groups, three with consumers and one with physicians, in each state. Participants in the three consumer focus groups comprised low-income consumers in 'the urban area,

disabled or chronically ill consumers in the urban area, and low-income consumers in the rural area. The physician focus group included physicians practicing in the urban area.[2]

1. Consumer Focus Groups

The size of focus groups ranged between 6 and 12 individuals. We generally recruited about 12 participants with assistance from the state Medicaid offices and local clinics or health centers, realizing that some would not attend. About two-thirds of the respondents in the low-income focus groups were enrolled in the demonstration programs. The remaining third were low-income uninsured individuals, who could provide other perceptions of the program and reasons for nonparticipation.[3]

An important issue in the shift to managed care is whether the programs are providing sufficient services to people with extensive medical needs. To explore this issue, we held a focus group with disabled or chronically ill people enrolled in the demonstrations. Since the Hawaii and Rhode Island initiatives did not include seriously disabled people (that is, those collecting Supplemental Security Income), we sought individuals with problems such as diabetes, asthma, or mental illness or parents of developmentally disabled/delayed children.

We followed a standard approach to conducting focus groups (Krueger 1988). Generally, a trained moderator led the focus group, while the research team observed and took notes. Outside observers were not allowed to attend. At the beginning of the discussion, a short baseline questionnaire was administered to gather information on participants' demographic characteristics, household composition, insurance status, and participation in the demonstration program. The following topics were covered in the ensuing discussion, which lasted between 60 and 90 minutes: personal background, experience with the demonstration enrollment system, selection of managed care plans and providers, relationships with

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[2]We did not conduct a physician focus group in the rural area, because of the logistical difficulties presented in organizing such a focus group. Rather, we interviewed individual doctors in the rural areas

[3]In Rhode Island, all of the focus group respondents were RIte Care enrollees.

primary care providers, access to specialized care, comparisons with Medicaid and private insurance, and health care alternatives.

2. Physician Focus Groups

Our main area of interest was the reaction of "regular" office-based physicians to the new managed care programs. In selecting focus group participants, we concentrated on primary care physicians who were participating in the demonstrations through non-staff-model managed care plans. We believe that physicians in staff-model HMOs have a very different set of experiences and that, because they are often salaried, they are less directly affected than office-based doctors by changes in reimbursement practices We also limited the group to doctors actively involved in patient care through one or more of the demonstration MCOs. We drew from the following physician specialties: internists, family and general practitioners, obstetrician/gynecologists, and pediatricians.

In recruiting physicians, we enlisted the help of MCOs participating in the waiver programs as well as the local medical society.[4] Each non-staff-model MCO and the local medical society were asked to suggest several physicians on the basis of the guidelines discussed in the preceding paragraph. In addition, we stressed that we were not interested in identifying the most active or vocal physicians; rather, we wanted to understand the views of "typical" physicians, We then selected 12 physicians from those suggested.

As with the consumer focus groups, the basic approach to the physician focus groups was to convene a focus group of physicians, a moderator, and research staff. A brief questionnaire was administered to obtain basic information about the respondents: their specialty, type of practice, and participation in the predemonstration Medicaid program and in the demonstration program. The following topics were discussed: professional background; experience with Medicaid before the demonstration; experience with

[4]In Rhode Island, researchers also selected some physicians from the RIte Care provider lists, and in Tennessee, researchers also recruited physicians with help from local hospitals.

managed care; selection of demonstration managed care plans; payment issues; relationships with MCOs; and changes in patients, patients' understanding of managed care, and quality of care under the demonstrations.

C. OFF-SITE MONITORING

Off-site monitoring of the demonstrations by the evaluation team is an ongoing process. It supplemented the site visits and focus groups, by allowing us to remain abreast of program operations and trends. Monitoring involves follow-up telephone interviews on a periodic basis with a key contact person in each state, as well as with HCFA staff, and review of written sources of information, including quarterly reports and local newspapers.

III. RHODE ISLAND'S RITE CARE PROGRAM

In August 1994, Rhode Island launched a Section 1115 demonstration to move its Medicaid population of pregnant women, children, and other family members into a fully capitated managed care program called RIte Care. RIte Care differed from the other demonstration programs of the same period in two key respects. First, although the state hoped to achieve some modest expansions in enrollment for pregnant women and children, RIte Care's primary focus was to improve access to primary care. Second, RIte Care sought only to control the rate of growth in Medicaid expenditures, not to achieve considerable savings.

A. BACKGROUND

Like most New England states, Rhode Island has always had a relatively generous Medicaid program, with many optional services, few limits on utilization, and more generous than average financial criteria for eligibility. However, the following were serious concerns about Rhode Island's Medicaid program prior to the Section 1115 demonstration:

- Seventy-five percent of the state's Medicaid dollars for Aid to Families with Dependent Children (AFDC)-related families were spent on inpatient hospital care.
- Medicaid physician payment levels were among the lowest in the nation (around $18 per routine visit), thus seriously depressing physician participation in Medicaid.
- A primary care task force in the state estimated that 50 percent of inner-city residents were receiving their primary care in hospital emergency rooms.
- Access to specialty care was difficult for the Medicaid population, with some community health centers reporting a 6-month wait for referrals to specialists.
- Many enrollees had language, transportation, cultural, and knowledge barriers to effective medical care.
- Between 1990 and 1992, Medicaid expenditures for AFDC-related enrollees increased by 4 1 percent, with only about one-third of the increase attributable to enrollment growth.

The state was also concerned about its growing uninsured population. Rhode Island experienced an economic downturn in the early 1990s. The unemployment rate rose from 7.5 percent in 1990 to 12.5 percent in 1992.

Prior to the demonstration program, the state had already started to focus on expanding coverage for low-income pregnant women and children in reforming its Medicaid system. In 1992 the Department of Health @OH) implemented a state-funded program to subsidize maternity costs for women with family income up to 200 percent of the federal poverty level. Furthermore, the state had received approval from HCFA for a 1902(r)(2) state plan amendment to extend Medicaid to pregnant women and children up to age 6 with family income less than 250 percent of the federal poverty level. (Once it became clear that the Section 1115 demonstration would be approved, however, this amendment was withdrawn.)

In 1993, Rhode Island had four Health Maintenance Organizations (HMOs) operating in the state: (1) HMO Rhode Island (HMO-RI), a Blue Cross affiliate; (2) Ocean State Physicians Health Plan (eventually subsumed under United Health Care); (3) Harvard Community Health Plan (HCHP); and (4) Pilgrim Health Care. Data for 1992 indicate the state's HMO penetration rate was about 26 percent, which was above the U.S. average of 16.1 percent (Group Health Association of America 1993). Thus, indemnity insurance was the dominant form of coverage in the state health market. Consistent with this pattern, Medicaid was predominantly fee-for-service. Medicaid participants could voluntarily join HCHP, but considerably less than 1 percent of the Medicaid caseload was enrolled in HCHP when the waiver application was submitted.

This chapter reviews and analyzes the first year of RIte Care experience. It is based primarily on interviews and focus groups conducted during weeklong site visits in May and August 1995, with more recent information used when available. We visited Providence, which is the state's capital and its major urban area (it includes 65 percent of the state's population). For a nonurban site, we visited what is called "South County," which is the southeastern part of Washington County in the southwestern part of the state.

Although it could not be called rural, the South County area is more sparsely populated and has a lower concentration of physicians than the rest of the state. During the site visits, we interviewed representatives from four hospitals, four community health centers, four of the five managed care organizations (MCOs) participating in RIte Care, and several professional provider associations and advocacy groups. We also interviewed state and local staff members associated with the RIte Care effort. We reviewed numerous documents provided by these representatives and HCFA staff, as well as two early studies of RIte Care's implementation: Rajan et al. (1994) and National Academy for State Health Policy (1994).

B. PROGRAM DESIGN AND IMPLEMENTATION

1. Development of the Design

In November 1992, then-Governor Bruce Sundlun appointed a health care advisory committee to address growing health care needs in Rhode Island. Although there was interest in moving the state to universal health care coverage, the committee recommended that the state concentrate its initial reforms in two areas: (1) incremental expansions of Medicaid eligibility for pregnant women and children; and (2) shifting the Medicaid population into managed care, beginning with families and children. During spring 1993, Rhode Island's demonstration proposal was developed, with staff from DOH playing a pivotal role. The state also brought in outside consultants (from Peat Marwick), since there were not enough state staff members with managed care expertise, and the state had a hiring freeze on. The demonstration application was formally submitted to HCFA in July 1993 and approved in November 1993.

For the most part, there seems to have been broad endorsement of the RIte Care demonstration effort. The move to require mandatory enrollment in managed care seems to have met little resistance, largely because HMOs were already a significant presence in the state's private sector health care system, and there did not appear to be any other viable cost-effective alternative for improving access to primary care for the state's low-income population.

Nonetheless, there were two areas of controversy during the demonstration development and pre-implementation phase that still have relevance. First, the state was criticized for failing to adequately involve consumers and community-based organizations in the demonstration development. However, RIte Care officials went to considerable effort to reverse this pattern during the planning phase prior to implementation, as well as during the first year of operations. For example, a decision to phase in enrollment resulted in part from consumer and community input. A second major area of controversy related to the role of the community health centers in RIte Care. The state estimated that the 14 community health centers throughout the state provided primary care to about 23 percent of the Medicaid population, while the community health centers contended they served 40 percent (Rajan et al. 1994). With either estimate, this is a much higher level of participation than in almost any other state. Most people in Rhode Island regard the community health centers as the state's safety net for the uninsured and Medicaid populations. It was some time before there was any certainty about exactly how the community health centers would participate in RIte Care, however, due to the difficulties of moving from cost-based Medicaid reimbursement to a capitated system. A year after implementation, it is still unclear how successful the community health center network will be in adjusting to managed care.

2. Key Design Features

We give a brief overview of the design here, with details of the RIte Care program presented in later sections of this chapter. The major objectives of the RIte Care program are: (1) to expand access to primary care, (2) to improve the continuity and quality of care, and (3) to control the rate of growth in Medicaid expenditures. To achieve these objectives, RIte Care required that the state's Medicaid population of pregnant women, children, and their parents enroll in managed care, with implementation to be phased in over a 1 -year period. Unlike the demonstration programs in Hawaii and Tennessee, RIte Care's eligibility expansions were modest; the family income threshold for pregnant women and children under age 6 was raised to 250 percent of the federal poverty level. The demonstration also includes an

extended 24-month family-planning program for pregnant women who lose Medicaid eligibility 60 days postpartum, and there are some expansions in the benefit package. Only HMOs fully licensed by the state are allowed to participate in RIte Care, and there was a competitive bidding process for MCO selection. The MCOs are paid on a fully capitated basis, although a few services (including dental) have been carved out and are paid on a fee-for-service basis. In addition to capitation payments, there is a special one-time-only supplemental payment for pregnant women, as well as a $10 per-member, per-month supplemental payment for RIte Care enrollees who designate a community health center as their primary care site.

The MCOs are required to use a gatekeeper model, with each enrollee assigned to one primary care physician. It is also significant that MCO contracts include a mainstreaming clause, which requires each MCO to agree that all of its network providers accept RIte Care members for treatment. The state offered reinsurance to all the MCOs, with options for a $25,000 or $50,000 threshold.

For the first year of operation, the Department of Human Services (DHS) and DOH together staffed the Office of Managed Care (OMC), the new state agency created to implement the RIte Care program. Oversight responsibility for OMC was given to an executive committee made up of the directors of DHS, DOH, and the Department of Administration, as well as a representative from the governor's office.[1] The state also awarded a management contract (which went to the Birch and Davis Health Management Corporation) to assist OMC in the day-to-day operation of RIte Care.

Several study respondents commented on the influence of DOH on RIte Care's design and credited DOH for the program's emphasis on public health objectives (such as reducing infant morbidity and increasing the use of prenatal care and preventive services). Over the demonstration period, DOH and an outside contractor (MCH Evaluation, Inc.) will play a major role, along with DHS, in a long-term evaluation of RIte Care. This evaluation will focus on the extent to which the program achieves its objectives for access, quality of care, and cost containment.

'In summer 1995, it was decided to consolidate the operations of OMC completely under DHS.

3. Startup

RIte Care implementation began in August 1994, with the expansion group eligible to apply from the start. The phase-in for current Medicaid enrollees (due for redetermination) began in September 1994. At the start, four commercial MCOs already operating in the state were selected to participate in RIte Care: (1) HCHP, (2) HMO-RI, (3) Pilgrim, and (4) United. The community health centers in Rhode Island also formed their own HMO--the Neighborhood Health Plan of Rhode Island (NHP-RI)--to participate in RIte Care. However, NHP-RI was not fully on board at the start of RIte Care since its HMO license was not secured until December 1994.[2] As discussed later, the state tried to ameliorate the effect of this delay for NHP-RI.

Many parties continue to express criticism about RIte Care's start date. Several study respondents mentioned that the state was not really ready but went ahead anyway because the governor (who was up for reelection but was eventually defeated in the Democratic primary) wanted RIte Care implemented before the November election. To this day, the community health centers believe the late entry of NHP-RI adversely affected its expected level of RIte Care enrollment. Finally, Rhode Island's Medicaid Management Information System (MMIS) became operational in December 1993, only 9 months before RIte Care began.[3] RIte Care implementation put its own demands on the MMIS, which was still struggling to meet the needs of the existing Medicaid system, particularly with regard to fee-for-service billing and timely provider reimbursement.

RIte Care had its share of problems in the early months, as one would expect with any large new program that significantly changes the health care system. However, the new Republican Governor,

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[2] Licensure of HMOs is a joint process involving both DOH and the Department of Business Regulation. DOH certifies access, availability, continuity of care, and quality of care requirements, whereas the Department of Business Regulation addresses financial solvency requirements and actually issues the license. To its credit, NHP-RI achieved its license in less than a year after applying for it. This was considerably less time than other HMOs required to obtain a license in the past.

[3] Because of its small size, Rhode Island was for many years the only state without an MMIS system.

Lincoln Almond (who took office in January 1995), and the legislature remained supportive of the demonstration program. At the end of the first year, both DHS officials and the Children's Code Commission from the state legislature undertook broad reviews of RIte Care's performance to identify areas that needed improvement. Several changes were planned; these are discussed later in this chapter.

C. PROGRAM FINANCING

The original budget estimates for RIte Care in Rhode Island's waiver application assumed expenditures of $708 million over 5 years for the RIte Care program (see Table III.1). This budget assumed that total Medicaid costs, including administration, would be higher under RIte Care in the first 2 years of the demonstration than they would have been under fee-for-service Medicaid, but that starting in fiscal year 1996, the cost of the RIte Care program would be less than expected under traditional Medicaid. As a result of the lower than expected costs in later years, RIte Care would achieve savings of $2.4 million over the course of the demonstration. These savings were to be shared by the state and federal governments at rates of 46.4 and 53.6 percent, respectively. Although the budget projected that administrative costs would increase by $8.3 million under the demonstration, this increase would be offset by savings in medical and transportation costs of $10.7 million. To finance the RIte Care demonstration, the state kept the current Medicaid budget intact and appropriated an additional $6.5 million to cover the program's expanded population and the administration of RIte Care. In addition, some DOH funds were shifted to the RIte Care program.

Unlike Tennessee, RIte Care's budget neutrality agreement with HCFA was not based on an aggregate budget spending target. Instead, RIte Care's budget neutrality is monitored using a "per-capita" spending target. The critical assumptions used to develop the initial budget neutrality agreement were:

- Per-capita Medicaid expenditures for the RIte Care population would rise at a slower rate under the demonstration than the per-capita expenditures would have increased for them under fee-for-service Medicaid (see Table lIt.2 for the expected rates of growth under managed care versus fee-for-service).

TABLE III. |

TOTAL PROGRAM COSTS BY STATE FISCAL YEARS
FEE-FOR-SERVICE AND RITE CARE
(In Thousands of Dollars)

	Fourth Quarter 1994	State Fiscal Year 1995	State Fiscal Year 1996	State Fiscal Year 1997	State Fiscal Year 1998	First Three Quarters 1999
Direct Costs						
Existing fee-for-service program	$26,320	$114,453	$121,735	$129,684	$1 35,546	$106,225
RIte Care	26,994	1 15,277	120,375	125,891	131,588	103,161
Administrative Costs						
Existing fee-for-service program	3,186	14,018	14,719	15,455	16,228	-12,779
RIte Care	3,561	15,768	16,319	17,055	17,828	14,154
Total Costs						
Existing fee-for-service program	29,506	128,471	136,454	1145,139	151,774	119,004
RIte Care	30,555	131,045	136,694	142,946	149,416	117,315
Federal Share (53.6 Percent)						
Existing fee-for-service program	15,815	68,860	73,139	77,795	81,351	63,786
RIte Care	16.377	70,356	73.314	76,665	80,133	62,997
State Share (46.4 Percent)						
Existing fee-for-service program	13,691	59,611	63,315	67,344	70,423	55,218
RIte Care	14,178	60,689	63,380	66,281	69,283	54,318
Difference (Existing--Rite Care)	-1.049	-2,574	-240	2,193	2,358	1,689

SOURCE: RIte Care demonstration application.

NOTES: Figures are for the RIte Care population only (Supplemental Security Income and other groups are not included). Total estimated cost savings under RIte Care for demonstration period = $2,377,000.

TABLE III.2

MONTHLY PER-CAPITA EXPENDITURES
1994-1999

	Managed Care	Fee-For-Service					
	Initial Demonstration Estimates'	Initial Demonstration Estimates'		Initial Terms and Conditions[b]		Revised Terms and Conditions'	
	Percent Increase	Monthly Per-Capita Expenditures	Percent Increase	Monthly Per-Capita Expenditures	Percent Increase	Monthly Per-Capita Expenditures	Percent Increase
State Fiscal Year 1 994[d]		$120		$119		$122	
State Fiscal Year 1995	6	130	8	126	8	129	6
State Fiscal Year 1996	4	137	6	131	6	134	4
State Fiscal Year 1997	4	146	6	136	4	139	4
State Fiscal Year 1998	4	151	4	142	4	145	4
State Fiscal Year 1999	4	157	4	147	4	150	4

SOURCE: Initial per-capita expenditures and inflation rates are from Rlte Care demonstration application. Revised and final per-capita expenditures and inflation rates are from letter to Debbie Van Hoven at HCFA from Tricia Leddy, Rlte Care Administrator, dated October 1995.

'Initial cost estimates and inflation factors used in demonstration application and initial budget.

'Revised cost estimates and inflation factors under terms and conditions

[c] Final cost estimates and inflation factors verbally agreed to by HCFA on October 12, 1995.

[d] State fiscal years run from July 1 to June 30.

- Administrative costs and fee-for-service expenditures for retroactive and carved-out services were excluded from the per-capita calculations.
- Both current Medicaid enrollees and the expansion groups were considered together in the baseline cost estimates because the state could have enrolled the vast majority of its expansion groups under a 1902(r)(2) amendment.[4]

Using these assumptions, a per-capita spending target was developed for each year of the demonstration. The yearly targets are the product of the number of actual member months covered under the demonstration in a given year and the per-capita monthly fee-for-service costs that would have occurred during that year without the demonstration. (These per-capita monthly fee-for-service costs were based on 1992 per-capita monthly costs for services covered under the plans' capitation rates trended forward by predetermined inflation factors set out in the terms and conditions of the demonstration. The inflation factors were developed on the basis of negotiations between HCFA and RIte Care officials and were renegotiated in the first year of the demonstration.)

The overall spending target for the demonstration, on which overall budget neutrality is based, is the sum of the five yearly spending targets. For the demonstration to be considered budget neutral in a given year, per-capita monthly costs under managed care need to be lower than the per-capita monthly costs expected to have occurred under fee-for-service without the demonstration. In other words, spending under RIte Care must remain below what it would have been if RIte Care enrollees used fee-for-service. With this formula, Rhode Island is only at risk for keeping the level of managed care per-capita costs associated with the demonstration under control, not the number of enrollees. The state is therefore protected from changes in AFDC caseloads or economic downturns.

As mentioned previously, the assumed rate of inflation that was used to calculate budget neutrality was lower under managed care than under fee-for-service. Under subsequent revisions during 1995 to the terms and conditions of the demonstration, however, the inflation rates under fee-for-service were modified

[4]Only the 24-month extended family planning coverage for post-partum women could not have been covered under 1902(r)(2).

and are currently the same as those under managed care (see Table III.2). The inflation rate that was used to trend 1993 baseline data to 1994 was also adjusted, however. The adjustment in the predemonstration cost inflation factors means that a higher (relative to the initial terms and conditions) per member, per month cost estimate under fee-for-service will be used in the budget neutrality cost calculations, despite the lower inflation rates over the course of the demonstration. Nonetheless, with the expected inflation rates now the same under managed care and fee-for-service, it is no longer clear whether there will be any cost savings under the RIte Care program. This is not inconsistent with the state's objectives. State officials have maintained all along that the objectives of the RIte Care program are to control the rate of growth in per-capita Medicaid costs and to improve access to care, instead of to achieve per-capita cost savings.

Table III.3 presents the state's preliminary cost estimates for the first project year. Under a conservative approach, it appears that the per member, per month costs were $115, based on the capitation rates and supplemental payments for FQHCs and pregnant women. This was almost 6 percent less than the expected $122 per-capita costs estimated for state fiscal year 1995 (the first year of the demonstration) for fee-for-service Medicaid. Therefore it seems that the state has been able to control costs in the first year. The state had expected costs to be higher under RIte Care relative to fee-for-service Medicaid in the first 2 years of the program. The implications of the lower than expected per-capita costs in the first year are unclear at this point and will be more thoroughly examined. For example, both the age/sex distribution of those enrolling in the program and program capitation rates affect per-capita costs. In our initial site visits, representatives from all the MCOs interviewed claimed that the capitation rates were too low, although none of them felt comfortable quantifying their views at this stage of the demonstration. Moreover, the state intends to increase capitation rates in the second contracting period. The lower per member per month cost ($115) under the first year of the demonstration (compared with the expected cost)suggests that the capitation rates should be carefully analyzed using enrollment, claim, encounter, and financial data.

TABLE III.3

ESTIMATED RITE CARE
MEDICAL EXPENDITURES FOR PROJECT YEAR
ENDED JULY 31, 1995

Type of Member	Member Months	Per Member Per Month Expenditure (in Dollars)	Total Expenditures (in Dollars)
Male/Female Ages 0 to 1	24,925	$250.49	$6,243,370
Male/Female Ages 1 to 5	83,314	53.33	4,443,137
Male/Female Ages 6 to 14	89,371	44.74	3,998,479
Male/Female Ages 15 to 44	17,395	70.47	1,225,817
Female Ages 15 to 44	124,623	113.81	14,183,359
Male/Female Ages 45 to 64	6,317	137.96	871,435
Pregnant Women Supplemental Payment	2,078	3,843.34	7,986,469
Extended Family Planning	500	22.80	11,400
FQHC Supplemental Payments			950,000
Subtotal	**345,945**[b]	**$115.38**	**$39,913,466**
Carved-Out Mental Health			786,526
Dental			588,346
Retroactive Fee-For-Service			2,167,592
Medical Care Subtotal			**$43,455,931**
Administration			6,663,922
Program Total			**$50,119,853**

SOURCE: Calculations provided to Lisa Dubay by Birch and Davis Health Care Management Corporation upon request.

FQHC = Federally Qualified Health Center

"These project year expenditures do not include fee-for-service expenses for enrollees before they were phased-in to RIte Care.

[b]The member months for pregnant women and extended family planning beneficiaries are excluded from the total.

D. ELIGIBILITY AND ENROLLMENT

1. Eligibility Policy

The RIte Care program focuses on children and their parents, as well as pregnant women. Aged and disabled people (including Supplemental Security Income [SSI] children), foster-care children, and any children or adults who are institutionalized are excluded. The demonstration allowed four significant changes in eligibility policy:

1. Higher income levels for pregnant women and children under age 6 (referred to as the expansion groups)
2. Elimination of assets testing (although this is still required to receive AFDC cash assistance)
3. A guaranteed 6 months of eligibility for enrollees initially participating in RIte Care
4. An extended family-planning program for pregnant women who lose eligibility 60 days postpartum.

The income levels for eligibility are 250 percent of the federal poverty level for pregnant women and children under age 6, 100 percent for children born after September 30, 1983, and 72 percent of the federal poverty level for families and other children (the state's medically needy level).[5,6] Three months retroactive coverage (to cover any medical expenses that may have occurred prior to application) continues for all enrollees who need it, if they can demonstrate that they would have been eligible then if they had applied.

'People with income above the medically needy level who must spend down to achieve Medicaid eligibility are not enrolled in RIte Care; they qualify for coverage under the fee-for-service provisions.

[6]Although not a part of the demonstration or Medicaid, state funding covers pregnant women with income below 350 percent who are ineligible for RIte Care (such as certain groups of aliens), as well as all pregnant women with incomes from 250 to 350 percent of the federal poverty level. In addition, RIte Care health plans are required to make coverage available to four other groups: (1) older siblings (ages 6 to 18) of children enrolled in RIte Care with family income less than 250 percent of the federal poverty level, (2) a conversion group of people who have lost their eligibility for RIte Care, (3) uninsured children under age 6 with family income more than 250 percent of the federal poverty level, and (4) pregnant women with income more than 350 percent of the federal poverty level. Neither federal nor state funds are involved with these four groups. These individuals are required to pay their own premiums and are not considered to be part of the RIte Care program.

After eligibility is determined, fee-for-service Medicaid is used until enrollees receive confirmation that they have been enrolled in a RIte Care MCO (this would not be expected to take more than a few weeks), as well as for any retroactive coverage period. Enrollees in the expansion groups are required to sign a statement indicating that, within the past year, they have not refused or canceled insurance that would have cost less than $150/month per individual or $300/month per family.

RIte Care imposed cost-sharing requirements on the expansion group enrollees. They have the choice of paying monthly premiums or point-of-service copayments. The monthly premiums vary by the age of the enrollee and the selected MCO's capitation rate. Although the premiums are low (for example, about $3/month for a pregnant woman age 15 to 44 and $7/month for an infant under age 1), few enrollees have elected the premium option. The copayments include $5 for all ambulatory care encounters (except for prenatal and preventive visits), a $15 copayment on ambulatory surgical procedures, a $25 copayment for each hospital admission, a $2 copayment per prescription, and a $3 5 copayment for nonemergency use of emergency transportation. Although there were initial plans for a $25 copayment for unauthorized and inappropriate use of the emergency room, this was eliminated early on at HCFA's insistence. The MCOs have complete responsibility for premium and copayment collection.

2. Eligibility Operations

Changes also occurred in Medicaid eligibility operations with RIte Care. A new group of 17 RIte Care workers was added statewide. Their responsibilities were to conduct intake interviews for applicants to the expansion group and to provide nonbiased enrollment counseling to the expansion group members, as well as to Medicaid-eligible enrollees (after their Medicaid redeterminations had been completed). In addition, DOH set up a RIte Care toll-free information line to provide information about RIte Care and how to apply. At the time of the site visit, seven telephone operators (two of whom were multilingual) staffed the information line 7 hours a day, 5 days a week.

As in the past, all routine Medicaid eligibility determinations and redeterminations are done by staff at local offices of DHS. The RIte Care workers responsible for eligibility determination for the expansion groups are also located in these offices. Although everyone is encouraged to apply in person, any applicant can apply to RIte Care by mail.

There was no change in the certification period. AFDC cash assistance recipients are redetermined every 6 months. All other RIte Care enrollees (including the expansion groups) are redetermined annually. There are no recertification requirements for the 24-month extended family-planning benefit.

3. Enrollment Operations

All Medicaid-eligible participants up for redeterminations, as well as any new expansion eligibles, were strongly encouraged to come into the local DHS district offices for face-to-face, nonbiased enrollment counseling before they enrolled in RIte Care. This counseling takes place in both group and individual sessions. Generally, a RIte Care worker is responsible for explaining the managed care concept and introducing the five HMOs available. In addition, a video (in both English and Spanish) that provides an introduction to the RIte Care program is available. Two MCOs defrayed the costs of developing this video in response to concerns that RIte Care workers were not adequately explaining managed care and MCO selection under RIte Care. It is up to the RIte Care worker whether or not to use the video. It seems to be routinely used in the larger offices, where group counseling sessions are more common. Individual counseling sessions are more common in the smaller offices. Participants are encouraged to complete a plan enrollment form at the time of the counseling session, if possible. RIte Care workers have up-to-date directories available of physicians, hospitals, pharmacies, and specialists associated with each plan to help families make their selections. Applicants are encouraged to indicate their preferences for primary care providers on the enrollment forms.[7] The forms can also be taken home and submitted later. Although there was supposedly an initial requirement that a plan be selected within 14 days of the counseling

[7]RIte Care requires that the entire family unit select one health plan, although each enrollee can designate a separate primary care physician within the plan,

session, enrollees were given a much longer period of time in which to make a decision if needed. HCFA has since informed the state that enrollees must be allowed a minimum of 30 days to select a plan. Plans are prohibited from any direct marketing, but providers are permitted to post signs in their offices indicating the plans in which they participate.'

Although encouraged, face-to-face enrollment counseling is not a program requirement for any RIte Care participants. Instead, a mail-m enrollment form can be submitted. Enrollees are supposed to return the marl-in enrollment form within 30 days.

For people who do not select a health plan, RIte Care automatically assigns them. By early 1995, only two plans (United and NHP-RI) had the capacity to accept new members. Generally, the split is 60 percent to United and 40 percent to NHP-RI. This assignment is based on an algorithm designed to favor MCOs with less expensive capitation rates. As of February 1996, 6.5 percent of RIte Care enrollees had been auto-assigned (that is, they did not select their MCOs). Appeal procedures exist for enrollees dissatisfied with the plan to which they are auto-assigned.

In 1995, RIte Care had a staggered open enrollment process, allowing those who had been enrolled in the program for one year the opportunity to change plans. The first open enrollment period occurred between August 15 and September 15, 1995, for those enrollees who had been in RIte Care for a year at that point. Of the 20,000 families who participated in the first wave of open enrollment, fewer than 5 percent elected to change plans. Open enrollment continued through 1995 as enrollees completed a year of enrollment with RIte Care. In 1996, RIte Care will have a fixed open enrollment period for the total population, from August 15, 1996, to September 15, 1996, with an effective date of October 1, 1996. Plan switches are also allowed at any time if recipients can show evidence of poor-quality care, lack of access

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'There have been some complaints that larger plans such as United and HMO-RI have an unfair advantage because they are able to undertake extensive general marketing in the state.,

to necessary specialty services or transportation, discrimination, or other good cause. As of November 1995, about 3 percent of enrollees had requested changes under these provisions.

4. Enrollment Trends

Rhode Island's demonstration application estimated that monthly enrollment in RIte Care would reach approximately 75,000 children and adults in the first year of operation. Of these, 65,000 (23,000 adults and 42,000 children) would qualify under existing rules, while an additional 10,000 would qualify under the expansion groups (9,000 children and 1,000 pregnant women). As Table III.4 shows, 70,020 participants were enrolled in RIte Care as of November 1995. Of these, only 1,030 were reported for the expansion groups, of which 316 were pregnant women. An additional 741 postpartum women were enrolled in the extended family-planning program. Thus, RIte Care has fallen considerably short with regard to its expansion group enrollment and somewhat exceeded its expected enrollment for those qualifying under the old rules. Rhode Island uses a highly automated eligibility determination system, and this system assigns new enrollees to the Medicaid-eligible or expansion groups. This automation increases the probability that such assignments are done accurately.

Most study respondents believe that the initial estimates of the potentially eligible expansion population were flawed and that the state has reached most of those who could qualify. Some respondents, however, believe the state has fallen short in its outreach efforts.

5. Eligibility Changes for Year 2

Several eligibility changes are planned for Year 2. In summer 1995, the state legislature voted to increase the age limit for expansion children to those less than 8 (instead of 6) years of age. Since it took some time for HCFA to approve this change, some children who became 6 years old "aged out" of the

TABLE IU.4

NUMBER OF ENROLLEES IN RITE CARE,
NOVEMBER 1995

Medicaid Children	44,632"
Medicaid Adults	23,617"
Expansion Group Children	714
Expansion Group Pregnant Women	316
Extended Family-Planning Women	741
Total	70.020

SOURCE: RIte Care program statistics.

"Estimated enrollment distribution between children and adults.

program after Year 1.[9] This was upsetting, since the legislature thought it had moved quickly enough to prevent such an occurrence. As a result, the state will be requesting an additional waiver amendment to expand RIte Care to all children through age 17, as resources permit. Although implementation is not expected immediately, RIte Care hopes to phase in this scope of coverage. With this amendment, the program in future years will not again have to face children "aging out" of the program unnecessarily. In addition, the outstationing of RIte Care workers will be increased, particularly at the community health centers, to ensure that every attempt is made to enroll uninsured people in Medicaid, with an emphasis on the expansion groups.

Plans for the second year also include the development of an ongoing consumer education program to address concerns that enrollees still have much to learn about their responsibilities under managed care. Another change is that OMC has made a commitment to institute enhancements to the computer systems that the eligibility workers use. There have been many complaints from staff members about their lack of access to MMIS screens that provide current enrollment status information. In Providence, for example, only supervisors can obtain information from the MMIS about the MCO enrollment status of RIte Care participants. Without direct access to this information, RIte Care workers are not able to fully inform demonstration participants about when their MCO enrollment takes effect. There will also be improvements in the process for enrolling newborns into RIte Care on the MMIS. The procedures for newborn enrollment have been poorly specified and inefficient.

Finally, several steps will be taken to improve the accessibility of RIte Care to Hispanic and other non-English-speaking population groups. In the Providence area in particular, there are many RIte Care enrollees who are not English-speaking and/or who have different cultural backgrounds from most enrollees. Initially, RIte Care was criticized for not adequately addressing the needs of these groups. In

[9]HCFA approved an amendment to RIte Care on February 19, 1996, to extend coverage to children less than 8 years of age with family incomes of less than 250 percent of the federal poverty level.

response to consumer complaints, the MCOs are being actively monitored to ensure they are meeting contract requirements regarding non-English-speaking enrollees." There already has been progress, with membership materials developed for the following languages: Spanish, Cambodian, Laotian, Portuguese, Hmong, and French.

E. SERVICE COVERAGE

The RIte Care benefit package is comprehensive and includes most of the optional services available under Medicaid. In the first year of operations, there were some limits on mental health and substance abuse benefits, including 20 individual or group therapy visits for mental health per year, 20 substance abuse therapy visits, and 15 inpatient hospital days." In-plan mental health benefits had to be provided only to the extent that MCOs believed they were medically necessary, and the MCOs varied as to the number of initial mental health benefits that they allowed enrollees before further authorizations were required. Some mental health services were covered but were carved-out of the RIte Care benefit package, including treatment beyond the in-plan limits on a fee-for-service basis if authorized by the state. Adults and children with serious mental health problems could have their mental health treatment entirely outside the capitation rate if they were approved by the state. Although there were no limits on eye care for children, adults were limited to one exam and one pan of glasses, if needed, in a 2-year period. Dental care was also a carved-out service and continued to be reimbursed on a fee-for-service basis. Other carved-out services included methadone maintenance and outpatient methadone detoxification, residential treatment services, and early intervention services for children at risk.

'We Care policy requires each MCO to make its membership materials available in a language other than English, if more than 50 of its members speak that language. Interpreter services are required if more than 100 enrollees, or 10 percent of the plan's RIte Care membership, speak a language other than English as a first language.

"This annual limit for inpatient days was combined for mental health and substance abuse.

There were additions to the Medicaid service package with the move to RIte Care. Probably most significant was the comprehensive package of family-planning benefits for 2 years to women who would otherwise become ineligible for Medicaid 60 days postpartum.[12] Some enhanced services were added with RIte Care, including nonemergency transportation, interpreter services, childbirth education, parenting education, nutritional counseling, and smoking cessation classes.[13] Finally, as part of the original plan for RIte Care, DOH was supposed to establish a network of neighborhood-based support teams to assist MCOs in addressing the nonmedical problems and social needs of RIte Care enrollees. '(These neighborhood support teams were not implemented in the first year, however, because of concerns that they might duplicate targeted case management benefits provided by the MCOs.)

In addition to these important benefit package changes, RIte Care imposed a specific set of service standards on the health plans. These standards include the following:

- Coverage must be available 24 hours a day, 7 days a week.
- A primary care physician whose office is located within 20 minutes driving time of the member's residence must be available to every member.
- Service must be available within 30 days for treatment of a nonemergency, nonurgent medical problem.
- Services for urgent medical problems must be available within 24 hours.

The 24 hours a day/7 days a week standard was particularly difficult for some of the community health centers that did not provide this level of accessibility before. All of them seemed to agree, however, that this was a desirable improvement in the service package for Medicaid enrollees.

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[12]The family-planning services include an annual physical exam and contraceptive medical visits, family-planning education and counseling, laboratory services ordered at family-planning visits, and pharmacy services (including medications and birth control methods) ordered at a family-planning visit.

[13]With RIte Care, the state began a public bus voucher system to assist Medicaid enrollees. These bus passes, called RIPTA passes, are issued for a 2-month period and are not restricted to medical use. Funding for the RIPTA passes is included in the capitation rates.

Some concerns developed over time with the RIte Care benefit package. Three frequently mentioned problem areas were:

1. Emergency *Care.* One impetus for the move to RIte Care was that many Medicaid enrollees were accustomed to receiving their care in hospital emergency rooms. However, consumers and providers have found it difficult to change this pattern. The situation was made worse by prolonged confusion over RIte Care's policies concerning emergency room care. At first, the state and HCFA disagreed about whether the state could impose copayment obligations for all enrollees who used emergency care inappropriately. However, HCFA made it clear that no copayment obligations could be imposed on categorically needy enrollees. Eventually, everyone agreed that copayment obligations for unauthorized emergency room use would ***not*** be imposed on any RIte Care enrollees. Confusion continued, however, over what the prior approval procedures were that consumers, hospitals, and MCOs were supposed to follow. As a result, concern developed that some RIte Care enrollees were afraid to use emergency room services, even when appropriate.

2. ***Mental Health Benefits.*** Providers and enrollees have been frustrated with mental health coverage under RIte Care. One of the most troubling areas has been RIte Care's relationship with Rhode Island's child welfare agency, the Department of Children, Youth, and Families (DCYF). Prior to the waiver program, DCYF was accustomed to using Medicaid financing and a select provider group to undertake court-ordered assessments of children for whom there were allegations of abuse and neglect. With the transition to RIte Care, it became a "gray" area as to whether or not these assessment services were part of the capitated package of benefits. Furthermore, many providers used by DCYF were not in the provider networks established by the five MCOs. As a result, DCYF experienced problems getting Medicaid to pay for services that it used to cover. Even when an MCO agreed to cover needed assessment services, DCYF was not able to use the providers it preferred. Other mental health issues included the arbitrary limits set by the MCOs on initial visits, the application process for both children and adults with serious mental illness (who become eligible for fee-for-service mental health benefits), restrictive staff credentiahng by the MCOs (which excluded some of the few multilingual mental health providers in the state), and allowable charges by mental health staff to the MCOs (for example, time spent in court to testify in cases involving assessment evaluations).

3 ***Nonmedical Services.*** Because a decision was made not to implement the plan for neighborhood support teams, most MCOs had to quickly set up their own referral networks for nonmedical social services. During the first year, many providers reported being overwhelmed by the level of needs and are frustrated that the state did not come through as promised in providing assistance.

As a result of these problems, the service package will be modified in the second year. OMC's in-house review indicated that many first-year service-related problems in RIte Care were caused because

the state had not developed a meaningful definition of medical necessity to use with providers. The state's new definition will be:

> Medically necessary services are defined as medical, surgical or other services required for the prevention, diagnosis, cure or treatment of a health-related condition including such services necessary to prevent a detrimental change in either medical or mental health status. Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the member or service provider.

As a result of this change, the state will be dropping its limits on care for mental health and substance abuse treatment, Plans will be expected to use the medical necessity criteria as a utilization management tool, instead of following artificial limits. However, there will be a stop-loss provision under which the state will reimburse MCOs for some benefits exceeding specified limits. [14]

Another change planned for Year 2 involves emergency services. RIte Care will require that health plans pay for a medical screening examination in an emergency room or freestanding emergency care facility to determine whether an emergency exists. Furthermore, consumers will no longer be required to telephone the MCO (or their primary care case manager) for approval before they seek emergency room care. They will not be required to pay for the cost of the medical screening examination or for any subsequent treatment of any emergency medical condition. However, any subsequent treatment for a nonemergency condition will require health care plan approval (in a timely manner). If this approval is given, consumers will not be held financially responsible for the treatment. If approval is not given, consumers will be informed that they will be charged in full for the service before it is provided. This revised policy should effectively address consumer and provider concerns about emergency room care.

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[14]Under the stop-loss provision, the state will reimburse MCOs for the following expenses: mental health-inpatient care of more than 30 days, substance abuse rehabilitation inpatient care of more than 30 days, mental health outpatient care of more than 30 visits, substance abuse outpatient care of more than 30 visits, and long-term care in an intermediate or skilled facility in excess of 30 days. Reimbursement will be at 90 percent of the current approved state Medicaid rate or 90 percent of the actual cost to the plan, whichever is less.

It should ensure that consumers will not be scared away from seeking treatment when a potential emergency exists. On the other hand, it will permit the RIte Care program to continue its policy of discouraging emergency room use for nonemergency services.

In addition, a new nonmedical service will be added to the RIte Care package available from each MCO. The new contracts are expected to require that all MCOs contract with a network of social service providers. These networks will be responsible for providing the following nonmedical services (as needed) to RIte Care enrollees: risk assessment, development of a plan of care, service coordination and referral, and followup and monitoring. (In effect, these networks will provide the services that the original plan called for neighborhood support teams to provide.) This is a new direction for HMOs, and it will be interesting to follow up and see if this approach is effective in helping RIte Care consumers find help for their nonmedical service needs.

Some additional services will be carved out of the capitation benefit package, including several DCYF-ordered services (such as sexual abuse evaluations) and adolescent residential substance abuse treatment. Several previously carved-out services will be changed to in-plan during the second year, including methadone maintenance, outpatient methadone detoxification and collateral visits, and long-term care (in excess of 30 days). In the first year, consumers were allowed to self-refer to in-plan providers for mental health and substance abuse services. In the second year, this provision will be expanded to include annual gynecological visits, diagnosis and treatment of sexually transmitted diseases, and family-planning services.

Finally, MCOs will be permitted to ease their credentialing requirements (on an experimental basis) to increase the availability of multilingual providers. With the transition to RIte Care, several Spanish-speaking mental health providers who used to participate in Medicaid no longer qualified under the MCO provider credentialing requirements; this reduced access, when the overall intent of RIte Care was to expand it.

F. MANAGED CARE PLANS AND CONTRACTING

This section first describes the characteristics of the MCOs in RIte Care. Next it discusses them in the context of prior managed care. Finally, it discusses the contracting process and the state's role.

1. Summary of MCOs

Five MCOs--HCHP, HMO-RI, NHP-RI, Pilgrim, and United--were awarded contracts to provide acute-care services to RIte Care enrollees. Table III.5, which illustrates the plan characteristics, shows that there is a mix of nonprofit and for-profit MCOs participating in RIte Care. All of the plans except NHP-RI and United limited enrollment, thus making NHP-RI and United the MCOs with the largest number of RIte Care members. Competition between these two plans appears to be significant. HCHP is the only mixed-model HMO, offering staff-model, group practice, and physician network products. Most RIte Care members are served by HCHP's staff-model products. Finally, NHP-RI is a community health center-based plan offering primary care services through health centers and referrals to specialists through its network.

The following are key characteristics of each MCO:[15]

- HCHP is the only mixed-model MCO involved in RIte Care and the only MCO that had a contract to serve Medicaid patients prior to RIte Care. HCHP limited its enrollment to 7,000 RIte Care members and set other limits by site. Most of its RIte Care members are enrolled in its Providence Center site.

- HMO-RI is a fully owned subsidiary of Blue Cross/Blue Shield. During the bidding process, it limited enrollment to 15,000 RIte Care members. Dissatisfied with the final capitation rates offered by the state, it further limited enrollment to 5,000 RIte Care members but later raised the limit to 7,500.

- NHP-RI is a for-profit corporation owned by 14 community health centers in Rhode Island. NHP-RI has a management contract with NHP-New England. In addition, NHP-New England helped NHP-RI finance some of the capital RIte Care required for each MCO participating in the demonstration. NHP-RI was not licensed until December 1994 and has

[15]Pilgrim Health Plan is not described because it is the MCO with the most limited enrollment of RIte Care members, and it recently merged with HCHP.

TABLE III.5

RITE CARE DEMONSTRATION CHARACTERISTICS OF MANAGED CARE PLANS

Plan	Plan Type	Enrollment Caps	FQHC Contracts	RIte Care Members as of November 29, 1995	Commercial Lives Insured
Harvard Community Health Plan of New England (HCHP)	Nonprofit Staff and group model	7,000, contract limits by site/center	No	4,457 (6.4 percent)	90,000
Health Maintenance Organization Rhode Island (HMO-RI)	Nonprofit 100 percent owned by Blue Cross/Blue Shield IPA model	7,500	Yes	8,100 (11.6 percent)	unknown
Neighborhood Health Plan of Rhode Island (NHP-RI)	For profit Health-center based Serves only RIte Care	Unlimited	Yes	20,834 (29.7 percent)	0
Pilgrim Health Plan	For profit IPA Model	1,250	No	918 (1.3 percent)	Unknown
United Health Plans of New England	For profit IPA model Wholly owned subsidiary of United Health Care Corporation	Unlimited	Yes	35,711 (5 1 percent)	200,000

'Percentage of RIte Care members.

FQHC = Federally Qualified Health Center; IPA = Independent Practice Association

the second-largest enrollment of RIte Care members, serving almost 30 percent of RIte Care enrollees.

- United is a for-profit, fully owned subsidiary of the Minneapolis-based United Health Care Corporation. It currently insures 50 percent of all RIte Care enrollees and has the largest commercial managed care market share in Rhode Island.

2. Managed Care Market for Medicaid

Despite the higher than average level of HMO penetration in the state, the implementation of the RIte Care program represented an important departure for the Medicaid program in Rhode Island from a traditional fee-for-service reimbursement system to one in which the state purchases insurance from MCOs. Prior to RIte Care, the state had contracted with one federally qualified I-IMO to provide health services to Medicaid recipients on a prepaid basis. Since 1972, HCHP contracted with the state to provide medical care on a prepaid basis to AFDC recipients who voluntarily enrolled in HCHP.[16] Medicaid enrollment in HCHP peaked, with approximately 2,200 members, just prior to implementation of RIte Care.

Under the RIte Care demonstration, the state contracts with MCOs to provide acute care using a primary care gatekeeper model, for which MCOs are paid on a capitated basis. Under the gatekeeper model, each RIte Care member is assigned a primary care provider.[17] In addition to being the member's main physician, a primary care provider is required to make referrals for specialty care and other medically necessary services, maintain a current medical record for the member, and adhere to the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity schedule of well-child visits and immunizations for enrollees under age 21.

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[16]In later years, medically needy family groups and foster children were also allowed to enroll in HCHP.

[17]Primary care physicians can be family or general practitioners, pediatricians, obstetricians and gynecologists, or internists. In addition, primary care teams (at teaching facilities) or primary care sites (Federally Qualified Health Centers or rural health clinics) can be included in a MCO's network, but a "lead physician" responsible for managing a member's care must be assigned to each RIte Care member.

With RIte Care came two important changes in the overall managed care environment. First, NHP-RJ (the community health center-based MCO) was formed in response to the demonstration; at this point, it serves only RIte Care members. Second, only two of the preexisting MCOs had a primary care gatekeeper product available in the commercial market; consequently, two MCOs had to develop these products to participate in the demonstration. One of these MCOs is in the process of receiving approval to offer this new product commercially.

3. RIte Care Contracting Process and Policy Management

a. Bidding

For the first contracting period, the state invited MCOs to bid on contracts to serve the RIte Care population. [18] In August 1993, the state released a data book to MCOs interested in RIte Care that included information on utilization and expenditures under the current Medicaid program. A pre-request-for-proposal (RFP) document was released in September 1993. The state conducted site visits with MCOs that had filed letters of interest in participating in RIte Care as a result of the pre-RFP document, These visits were considered a readiness review and were a precondition of participating in the competitive bidding process.

MCO participation in RIte Care was limited to organizations that were licensed in Rhode Island as HMOs, although the state also opened the bidding to organizations that had begun the licensure process and were actively seeking licensure. However, MCOs in the latter category were not allowed to enroll RIte Care members prior to receiving licensure

The actual RFP for MCOs was developed under contract by Peat Mat-wick in conjunction with state officials and was issued in December 1993. MCOs were required to respond by the end of January 1994. Plans were required to provide bids for eight age and sex cohorts: (1) infants, (2) children ages 1 to 5, (3)

[18] The initial contracting period was for l year. However, the state extended the first contract by 6 months.

children ages 6 to 14, (4) males ages 15 to 44, (5) females ages 15 to 44, (6) adults age 45 and older, (7) pregnant women in the expansion group, and (8) expansion group females eligible only for extended family-planning benefits.

b. Negotiations

Seven health plans--HCHP, HMO-RI, Managed Care Administrators, NHP-RI, Pilgrim, United, and U.S. Healthcare--submitted bids. MCO capitation rate bids were compared with rate ranges developed for RIte Care by Mercer, the state's actuarial consultant. The rate ranges were developed around the costs associated with providing services included in the capitated rate for each age/sex cohort and were based on the cost experience of the Medicaid program from 1990 through 1992 for the AFDC-related populations. Bids by Managed Care Administrators and U.S. Healthcare were rejected because Managed Care Administrators did not meet minimum scoring requirements and U.S. Healthcare's bid was incomplete. Of the MCOs that were considered, few of their initial bids were within the state's range. After two rounds of negotiations, only NHP-RI and Pilgrim had accepted the state's final offer. Moreover, Pilgrim limited enrollment to 1,000 members, and NHP-RI only accepted the state's offer with the qualification that the state would bring payments to community health centers up to full cost-reimbursement levels.

With only two MCOs willing to participate, the state's purchasing officer consulted with HCHP, HMO-RI, and United (the three other MCOs that were acceptable to the state but did not accept the state's final offer) and determined that their central concerns involved the risk associated with the number of pregnant women who would enroll in their plans and the overall payment rates for pregnant women. To address MCO concerns, the state redesigned the payment scheme for pregnant women. The costs of prenatal care and delivery for all pregnant women with incomes below 185 percent of the federal poverty level were removed from the capitated rate for females ages 15 to 44, and a special supplemental payment

rate for all pregnant women was created.[19] Under the revised system, MCOs would receive the regular capitation rates for females ages 15 to 44 (including pregnant women) beginning with enrollment. The special supplemental payment would be made after delivery for each pregnant woman. This allayed MCO fears that they would be underpaid for deliveries and that they would be at risk if a disproportionate number of pregnant women enrolled in their plan. With this change, HCHP, HMO-RI, NHP-RI, Pilgrim, and United agreed to contract with the state to serve RIte Care patients. Contracts were awarded in March 1994. Table III.6 shows the first-year monthly capitated rates for each plan by age/sex cohort, as well as the supplemental payment rate for pregnant women after delivery.

At the beginning of the demonstration in August 1994, NHP-RI had not yet received HMO licensure from the state. NHP-RI argued to have the demonstration delayed until its licensure was approved. Instead, the demonstration went forward, and people eligible for RIte Care wishing to enroll in NHP-RI were allowed to remain in fee-for-service Medicaid until NHP-RI obtained its license. According to MCO representatives, this annoyed other MCOs, which maintained that NHP-RI was being given an unfair advantage. One MCO threatened to (but did not) sue the state over this matter. Representatives from NHP-RI maintained that their organization was put at a significant disadvantage in enrollment because the demonstration started prior to its licensure. They also alleged that enrollment counselors provided misinformation during the enrollment process regarding the ability of eligible people to enroll in NHP-RI prior to licensure.

[19]This payment was based on delivery costs of $4,400, from which 5 months of capitation was subtracted on the assumption that MCOs would also receive the regular monthly capitation payment. The final supplemental payment amount for deliveries ranged from $3,837.60 to $3,873.90 across MCOs. As discussed later, this rate was increased by $230 in August of 1995.

TABLE III.6

MONTHLY CAPITATION RATES UNDER RITE CARE, YEAR 1
(in Dollars)

	Infants	1- to 5-Year-Olds	6-to 14-Year-Olds	Male 15- to 44-Year-Olds	Female 15- to 44-Year-Olds	Over 45 Years Old	Extended Family Planning	Supplemental Delivery Payment[a]
Harvard Community Health Plan of New England (HCHP)	217.76	52.70	44.47	70.06	105.22	137.96	22.48	3,873.90
Health Maintenance Organization Rhode Island (HMO-RI)	217.76	52.70	44.47	70.06	105.22	137.96	22.48	3,873.90
Neighborhood Health Plan of Rhode Island (NHP-RI)	251.65	54.48	44.47	71.22	111.64	137.96	23.39	3,837.60
Pilgrim Health Plan	268.49	53.05	44.47	70.29	112.05	138.02	22.48	3,837.60
United Health Plans of New England	253.60	52.70	44.47	70.06	116.60	137.96	22.48	3,837.60

[a]This is not a monthly payment, but rather a one-time payment on delivery

c. Contracts Between the State and MCOs

Each MCO serving the RIte Care population holds a contract with the state that establishes numerous requirements. Probably the most striking of these requirements is the mainstreaming clause that requires the MCO's entire physician network to accept RIte Care members for treatment. Therefore, all providers in a MCO's commercial network must agree to accept RIte Care patients.[20] The contracts also contain requirements regarding provider networks, service availability, marketing restrictions, member services, benefit packages, management and quality assurance, reinsurance, and financial standards. MCOs have complete discretion concerning how providers are reimbursed.

The contracts contain several important items. First, the contracts between the state and MCOs stipulate that the ratio of members (all types of members for that MCO, not just RIte Care members) to primary care physicians may not be greater than 1,500: 1. However, physicians can contract with more than one MCO and accept non-MC0 patients, making these requirements appear relatively weak. The contracts do not specify maximum member-to-specialist ratios; instead, they state that there be a "sufficient number" of specialists to assure timely access to specialist services. Second, MCOs are required to contract with the community health centers, unless they can demonstrate that both adequate capacity and an appropriate range of services for vulnerable populations are available in a given service area without contracting with these entities. Third, MCOs are required to provide coverage either through the MCO or through their primary care physicians 24 hours a day, 7 days a week for authorization of emergency and urgent care. Fourth, MCOs are not allowed to market within 50 feet of RIte Care enrollment sites, and the state must approve all marketing materials. Fifth, building on the state's strong HMO licensure regulation, MCOs participating in RIte Care must meet all the DOH utilization review/quality assurance and financial standards for HMOs. In addition, they must meet RIte Care specific program standards. Finally, the state

[20]One MCO, HMO-RI, had an exception to this clause but assured the state that 87 percent of its commercial network would serve RIte Care patients. There were also allegations that United did not make all of its mental health providers available to RIte Care enrollees.

offered the MCOs the option to purchase reinsurance for the reimbursement of inpatient hospital costs incurred by members beyond a preestablished monetary threshold.

Representatives from the MCOs were cautious about revealing the specifics of their financial status with respect to RIte Care. Nevertheless, most felt that they were facing financial losses under the RIte Care program for the first year of operations. All of the plans interviewed, however, appeared to be financially solvent.

d. Quality Assurance/Improvement

The quality assurance/improvement program under RIte Care is based on the Health Care Quality Improvement System for Medicaid Managed Care (HCQUIS) developed under the Quality Assurance Reform Initiative (QARI). It builds on the Rhode Island DOH's Division of Facilities Regulation's quality-monitoring program for commercial HMOs. As licensed HMOs, MCOs contracting with the state to serve RIte Care members are required to have and implement comprehensive internal quality assurance plans. In addition, licensed MCOs must obtain National Committee on Quality Assurance (NCQA) accreditation within 2 years of licensure. Most other states do not require this accreditation for their Medicaid managed care programs.

The MCOs are also monitored to assure that RIte Care contract requirements for quality of care are met. These requirements are broader than for commercial plans for some services, such as EPSDT, enhanced services, interpreter services, and coordinanon with other state services. The state has developed a RIte Care specific quality-monitoring plan that includes monitoring internal quality assurance plans through initial and ongoing site visits, developing medical care policies and utilization standards, and analyzing encounter and other data for quality assurance and utilization review. The plan also includes conducting focused clinical studies and chart audits, conducting consumer satisfaction surveys, and defining and evaluating provider service networks. The state has conducted site visits with MCOs, is

currently monitoring MCO quality assurance plans, and is working with MCOs to identify and resolve problem areas.

e. Contract Year 2

The state extended the first contract year by 6 months to allow more time for obtaining accurate utilization data, which it will use to develop rates under the second contract. Our interviews suggested that the MCO response to this policy was mixed. Some MCO representatives stated the extension would allow them to perform a more complete actuarial analysis for bidding on the second contract. Other representatives, however, felt that the capitation rates in the first year were low and that extending them for another 6 months would only increase their financial losses under the program.

Many contractual changes are planned for the second contract year. These include using a broader definition of medical necessity in determining covered services, requiring MCOs to reimburse hospitals for medical screening exams in hospital emergency rooms, permitting plans to include mid-level practitioners in their provider networks, and strengthening the "mainstreaming" requirements. Another change will allow consumers to self-refer to in-plan providers for annual gynecological visits, family-planning services, and sexually transmitted disease services. (The proposed changes regarding in-plan and carved-out services were discussed earlier.) The state will no longer offer reinsurance to MCOs but will require MCOs to obtain such reinsurance in the commercial market. Finally, the supplemental payment for pregnant women upon delivery has already been raised by $230.

G. PROVIDER RELATIONS AND PARTICIPATION

1. Physicians

A physician focus group held in Providence involved 10 primary care physicians (including pediatricians and obstetricians/gynecologists) who were members of the three MCOs (HMO-RI, Pilgrim,

and United) that relied primarily on physician networks.[21] Participation in the group was restricted, to obtain the views of physicians from more traditional private practices. Appendix A includes a complete report on the physician focus group results.

The physician focus group revealed that primary care physicians in private practice were more content under RIte Care than under the traditional Medicaid program. This was mostly due to the higher payments they were receiving under RIte Care and the timeliness of those payments. However, physicians from a community health center and a hospital outpatient department raised serious concerns that the shift in the site of care from hospital outpatient clinics and community health centers to private physician practices may result in less appropriate services for non-English-speaking enrollees and enrollees with complex psychosocial problems (such as low educational attainment or substance abuse problems) because private practices do not have the resources to meet the needs of these types of patients. They further argued that community health centers and hospital outpatient departments remain the most appropriate setting in which to provide care to this population because of the additional time built into appointment slots and the presence of bilingual staff and psychosocial support services on site. Most physicians in the focus group felt that RIte Care enrollees did not receive adequate education from either the state or the MCOs regarding what managed care is and how it works. Moreover, they felt strongly that the lack of education meant that providers were responsible for educating RIte Care enrollees.

a. Physician Participation

According to state officials, provider participation in RIte Care is greater than under the traditional Medicaid program. In particular, the state felt that increased participation was likely to have occurred with obstetricians, many of whom did not participate in Medicaid prior to RIte Care. Although the state expected pediatrician participation to increase, the change would be of a lesser magnitude, since many of

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[21] Some of the physicians who attended also had contracts with NHP-RI.

them had historically participated in the Medicaid program. State officials attributed the increases in provider participation to the mainstreaming requirement that all physicians in an MCO network serve RIte Care patients, potentially guaranteeing participation by all physicians participating in commercial managed care plans. (Surprisingly, no evidence was discovered of widespread physician discontent with the mainstreaming policy.) State officials also felt the increased provider fees offered by the MCOs relative to the traditional Medicaid program were critical to this response. However, detailed data on the levels and intensity of provider participation were not initially available to support or refute the claim of increased physician participation. Recently, data have become available to address this question more definitively.

Nevertheless, state officials indicated that there were some geographic areas in the state where the number of physicians accepting new members relative to the number of RIte Care enrollees may be inadequate. In particular, state officials identified Central Falls, parts of Providence, Pawtucket, and Woonsocket as likely problem areas.

b. Payment Methods and Levels

Prior to RIte Care, the state's 1993 physician payment rates were 42 percent of Medicare fees, compared with 73 percent nationwide, and 62 percent for New England (Norton 1995). The general sense about the adequacy of payment levels under RIte Care was that physicians were reimbursed at levels that were higher than under the traditional Medicaid program but that reimbursement was still lower than for private patients. From inter-views with MCOs and physician focus groups, we were able to determine physician payment arrangements, as well as RIte Care physician payments, as a percentage of commercial physician payments for most MCOs.

Most physician payments under RIte Care are based on discounted fee-for-service. Depending on the MCO, payment rates for serving RIte Care patients range from 80 to 100 of each MCO's commercial payment rates. In addition to this variation in the discount off commercial rates, other variations in payment arrangements exist. One MCO offers a per member, per month payment to primary care physicians for

case management services. Another plan offers primary care physicians the choice between capitated or discounted fee-for-service payments. Finally, HCHP's staff-model physicians are salaried.

In summary, it appears that physicians serving RIte Care members are being paid at a level significantly higher than under the traditional Medicaid program. However, physician payments in most cases represent a level that is lower than commercial rates.

2. Hospitals

a. General Impressions

Hospital representatives were somewhat cautious about revealing their perceptions of RIte Care because they felt it was too early to assess the financial and other impacts of the program. During our site visit, we interviewed representatives from the Hospital Association of Rhode Island and from Rhode Island, Women and Infants, South County, and Butler hospitals. All hospitals in the state participate in RIte Care. Of the 15 Rhode Island hospitals, HCHP contracts with 10, HMO-RI with all 15, and NIP-RI, Pilgrim, and United with 12 each. In addition, United has a contract with one hospital in Massachusetts.

Hospital representatives indicated that emergency room visits were declining (although they were unable to estimate exactly how much). Moreover, to ensure appropriate emergency use, some MCOs have established managed care desks in some hospitals to authorize patient care in the emergency room. Except for Women and Infants Hospital, hospitals had no indication of the effects of RIte Care on length of stay or on number of inpatient stays.

b. Payment Methods and Levels

Most respondents indicated that hospitals were relatively well paid under Medicaid prior to RIte Care, During this period, hospitals were reimbursed by Medicaid on a prospective cost-finding basis. Costs were estimated through a negotiation among the hospitals, the hospital association, Blue Cross/Blue Shield, and the state. On the basis of the negotiated budgets, a rate was set for each hospital based on a ratio of

charges to costs for inpatient and outpatient services, with year-end adjustments for volume and other factors. In addition, both the state and Blue Cross/Blue Shield reimbursed hospitals for a share of uncompensated care costs. However, we were unable to obtain any information on payments under RIte Care relative to Medicaid.[22]

Hospitals are paid for services under RIte Care in several ways. One MCO negotiates individually with hospitals; most of its payment arrangements are based on per-diem or per-stay rates that vary across products, hospitals, and types of services. However, this MCO does have a risk-sharing arrangement with at least one hospital. Another MCO pays hospitals the same rate Medicaid had been paying prior to RIte Care. Most hospitals accepted this arrangement, except for one that negotiated higher rates. This MCO is considering risk-sharing arrangements in future contracts. Another MCO bases its payments to hospitals on a diagnosis-related group or per-diem basis. Most hospitals affiliated with this MCO are paid the same for their commercial and RIte Care patients, because contracts were already in place when RIte Care was implemented; however, this is likely to change in the future.

One controversy regarding hospital payments revolved around who was responsible for the costs associated with screening visits in emergency rooms. During the first year, not all of the plans were reimbursing hospitals for the screening fees. However, the state made the determination that MCOs were responsible for reimbursing hospitals for these services during this period.

3. Federally Qualified Health Centers

a. General Impressions

As mentioned earlier, Rhode Island has historically had a very strong base of community health centers that met the requirements of Federally Qualified Health Centers. According to representatives from their state association, health centers served approximately 55,000 patients a year prior to RIte Care.

[22]The state of Rhode Island has a disproportionate-share hospital program, which was not changed with the implementation of RIte Care.

Of these, 25,000 to 28,000 were potential RIte Care participants (low-income women and children). Respondents from most sectors indicated that Medicaid reimbursement to community health centers had been far below costs until the institution of cost-based reimbursement in 1990. With the implementation of RIte Care in 1994, health centers feared that, because MCOs would pay the same rates to physicians in private practice as to the health centers, some of the increased reimbursement health centers were receiving under cost-reimbursement would be filtered to private physicians who had traditionally not been willing to serve the Medicaid population. In short, health centers felt that they had much to lose under RIte Care.

Faced with these issues, health centers developed a community health center-based MCO: NHP-RI. All of the community health centers in the state contract with NHP-RI, and several also have contracts with other MCOs. In addition, health centers and the health center association lobbied the state to address the issue of cost-based reimbursement for health centers under the demonstration. As a result, a supplemental payment was instituted that provides community health centers with an additional $10 per member, per month for each RIte Care member designating a community health center as a primary care site, regardless of the MCO with whom the member is enrolled. The supplemental payments were designed to bring health center payments under RIte Care up to cost-based reimbursement levels. These payments are made by the state to NIP-RI, which distributes them to the health centers. Community health center representatives noted, however, that state grant monies previously allocated to community health centers were used as the state match for the supplemental payments. Community health centers no longer receive these grant monies, which they previously used to help cover the costs of serving the uninsured.

To their dismay, the community health centers and NHP-RI have not been able to secure the level of RIte Care enrollment they had hoped for Community health center representatives claimed that this was due in part to the delay in licensure of NHP-RI. Even though enrollees wishing to remain with a specific health center were allowed to remain in fee-for-service Medicaid until NHP-RI was licensed, community

health center representatives and advocates asserted that health centers lost members because the enrollment process was biased against them. It is unclear, however, whether lower than expected enrollment was due to disadvantages in the enrollment process in the early stages of RIte Care or RIte Care members' preferences for private physicians (discussed in Section H).

Several of the 14 community health centers have reported difficulties in covering their ongoing expenses, in spite of the supplemental payments. Respondents claimed that their revenues have fallen because their share of RIte Care enrollment was less than expected and they no longer receive cost-based reimbursement. At the same time, their uncompensated care expenses have increased due to growth in the state's uninsured population. Some centers are struggling to continue operating, and they have had to cut back staff, reduce salaries, or increase their lines of credit. Since the community health centers in Rhode Island are regarded as the state's safety net for low-income uninsured people, there is widespread concern about their future.

b. Contracting with MCOs and Payment Arrangements

HMO-RI, NHP-RI, and United all have contracts to provide care to RIte Care enrollees in community health centers. Under NHP-RI's payment arrangements, health centers receive a capitated payment for primary care services. In addition, NHP-RI maintains two internal funds: (1) a specialist services fund, and (2) a health facility fund. Year-end balances in the consultant services fund are returned to health centers, and balances in the facility fund are split equally between NHP-RI and health centers. The two other MCOs pay community health centers on a discounted fee-for-service basis. One MCO contracts with individual physicians in health centers and pays them 80 percent of the MCO's commercial rates. The other MCO contracts directly with some community health centers and pays them at 90 percent of the MCO's commercial rates, with a withhold of 10 percent.

H. CONSUMER VIEWS

Focus groups were held with low-income consumers in both Providence and South County to explore their experiences with the RIte Care program. A third focus group, which also took place in Providence, was made up of people whose families included a member with chronic health care needs. Appendix B presents a complete report on the focus group results. There were problems with recruiting participants for all three groups. In total, 14 people attended the meetings, including 12 RIte Care enrollees and 1 mother with children in RIte Care. The remaining respondent was the mother of a chronically ill child who used to be on Medicaid. The groups provided some insights about the conversion to RIte Care and consumer knowledge about managed care, but the results should be used with caution since the respondents were not intended to be a statistically representative sample of RIte Care enrollees.

Most members of the urban and nonurban low-income focus groups were satisfied with their new arrangements under RIte Care. Those who used to receive their care from clinics especially liked being able to choose their own doctors under RIte Care. Several mentioned the stigma associated with welfare and Medicaid and indicated they felt that RIte Care was more like the health care everyone else has. Their complaints about the program primarily related to the verification system and general managed care procedures (such as having to coordinate all care through a primary care physician). They had few complaints about individual plans or physicians.

a. Administrative Problems

Several respondents were frustrated with the Medicaid program's automated Recipient Eligibility Verification System. They indicated they had experienced delays in seeing physicians or having prescriptions filled because the providers were unable to confirm their plan enrollment. Respondents said that even the local DHS staff has trouble providing an accurate assessment of where cases stand in the automated enrollment system. On the other hand, there were generally positive comments about the helpfulness of local RIte Care staff and the information line workers.

b. Selection of Plans

Most respondents indicated they chose a health plan that included a doctor or clinic they had used before. No one had to change doctors, nor had any of the focus group participants been auto-assigned to MCOs. Several urban respondents indicated they transferred from a community health clinic to a private doctor with RIte Care. The poor recordkeeping at community health centers was cited as a problem area. (For example, one respondent said her center could never locate her medical records, and another said her center did not have any computers for record-keeping.) The major criticism with regard to plan selection involved the restrictive pharmacy and hospital networks with each MCO.

c. Emergency Room Access

In each group, some people did not understand the RIte Care rules regarding access to emergency services. Generally, participants seemed aware that they could not continue to use the emergency room for routine care. However, they had questions about how to decide what constituted an emergency and what steps they should follow. One respondent suffered through a weekend of great pain with what turned out to be kidney stones, because she was trying to follow the new rules. Another enrollee reported that she was initially denied permission by her MCO (by telephone) to use emergency services -over the weekend when her child fell down 13 steps and hit his head. She went anyway and eventually received approval. There also seemed to be some misperceptions about emergency room policies; one respondent claimed her plan allowed her to continue to use the emergency room as before, as long as she called the plan to tell them after she had been there.

I. OTHER VIEWS

Several advocacy organizations are actively involved in the RIte Care program. This was not true in the early stages of the demonstration development, and everyone agrees their participation has strengthened

the program, Many of the problems identified by advocates have already been mentioned. Other issues they cited include:

- Telephones are not easily accessible to many RIte Care enrollees, thus severely limiting their ability to use the managed care model (particularly with regard to emergency services authorization and appointment scheduling).
- Enrollees do not understand their grievance and appeal rights under RIte Care.
- Providers have not been educated about the gatekeeper concept under managed care and do not understand their responsibilities, particularly with regard to EPSDT.
- New rules regarding the deeming of step-parent income in eligibility determination are viewed as inequitable and have caused several children to lose RIte Care eligibility.

Beginning in August 1995, the Children's Code Commission, in cooperation with state officials, held a series of six public hearings over a 3-month period to review the first year of RIte Care operations. The Code Commission is made up of representatives from the legislature's Committee on Finance and the Committee on Health, Education, and Welfare. Many provider and advocacy group representatives testified, as did officials from state agencies involved with RIte Care. The thrust of the hearings was that most legislators support RIte Care but want to know how the program is doing and what they can do to make needed improvements. The commission responded positively to the second-year changes in RIte Care policies and operations proposed by DHS Director Christine Ferguson at the final hearing.

J. DATA ISSUES

As part of its MMIS, RIte Care intends to collect an extensive array of encounter data from each of the health plans. A unique feature of the system is that it includes a detailed record of every RIte Care delivery. This record includes the number of prenatal visits, the date of the first prenatal visit, the type of delivery, whether the pregnancy was high risk, and the birth weight and gestational age of the infant. In addition, all the MCOs will be reporting aggregate-level encounter data covering both RIte Care members and their commercial members, so that OMC can determine how service utilization and outcomes for the

RIte Care population compare with the general population of HMO enrollees in Rhode Island. OMC brought in outside expertise to assist in designing the system and also involved the five RIte Care health plans during the system-planning phase. The new system appears to hold great promise. It is not yet fully tested, however, and the 1994 data are not expected to be ready for review until spring 1996. Although the health plans report they have been collecting encounter data from the start, some problems are expected with the first year's data. It is hoped that these problems will be resolved by the second year.

Rhode Island's MMIS system was not implemented until December 1993. As a result, RIte Care will not have available the two full years of pre-implementation claims and eligibility data that were anticipated with the evaluation design. Because enrollment for RIte Care was staggered, the Medicaid-eligible enrollees who first converted to RIte Care will only have about 10 months of predemonstration enrollment and claims data from the MMIS, while those enrolled in the final stages will have no more than 22 months of data. Other Medicaid data from the predemonstration period are not sufficiently detailed to be suitable for use in the evaluation.

As mentioned earlier, there were many RIte Care implementation issues related to the MMIS. Most of these problems involved the efficiency and accessibility of the part of the system that confirms eligibility and plan enrollment status. Some respondents felt that addressing RIte Care eligibility problems was not a priority for MMIS staff and resources because children and families are not the expensive part of Medicaid. It also may have been a disadvantage that OMC was not officially a part of DHS or the Medicaid division in the first year of operations. It also seems likely that some difficulties occurred simply because the system was still new. To its credit, the Rhode Island MMIS includes more extensive information than that in most state MMIS systems, particularly concerning eligibility, encounter data, and providers. Indeed, the richness of the database may have contributed to the difficulties the state has encountered in getting it to work smoothly.

K. LESSONS LEARNED

Several aspects of Rhode Island's program were different from other state Section 1115 programs of the same period and helped ease the transition to managed care. RIte Care placed much greater emphasis on increasing primary care access than it did on enrollment expansion, was implemented in a state that already had an established managed care infrastructure, and made extensive use of outside expertise in managed care. RIte Care also focused more on cost containment than cost savings, and it elected to phase in implementation over a 1 -year period.

Other states may want to consider using the Medicaid eligibility redetermination process to trigger conversion to managed care, coupled with a guaranteed period of initial enrollment. In Rhode Island, these steps reduced the trauma associated with such a large system change. States should understand, however, that any change of this magnitude (even if somewhat gradual) will not be trouble free. In the early months, Rhode Island's newly implemented MMIS system was a source of great frustration, with errors and delays in notification to the MCOs of new enrollees. Consumers, local eligibility staff, and providers also had trouble verifying enrollment status for RIte Care participants. In addition, there were provider complaints about the confusion that occurred because they had to run two systems throughout the year: one for dealing with Medicaid enrollees who continued to be fee-for-service until they were up for redetermination and another for those enrollees who were now in the capitated system. Nevertheless, in hindsight, study respondents generally believed that other states would be well served by a phased-in enrollment approach.

Not enough can be said about the importance of consumer and provider education. Several techniques were employed to acquaint consumers with the RIte Care program, including face-to-face, nonbiased enrollment counseling, a video, and a toll-free information line. There was also a back-up mail-in system for plan enrollment, As a result, only 6.5 percent of enrollees through February 1996 were auto-assigned. Still, all study respondents agreed that more training about managed care is needed in Rhode Island, both for consumers and providers. In particular, the state's newly formed OMC did not undertake

enough early planning to adequately address the needs of non-English-speaking Medicaid enrollees in converting to a managed care system, and the MCOs were not prepared for the diversity in language and culture represented by the RIte Care population.

States should be aware of the importance of communication between stakeholders in developing managed care initiatives. In the early stages of RIte Care planning and implementation, Rhode Island was criticized for its failure to adequately involve consumers, advocates, providers, the managed care community, and other state agencies. Over time, the state took steps to address this problem. Now weekly meetings are held between OMC staff and representatives of all five MCOs (with other organizations attending as appropriate) to discuss problem areas and transmit policy and operational changes. Problem resolutions are not always as timely as everyone would like, but the critical participants are involved. The state also set up a Consumer Advisory Committee that meets monthly and allows advocates and representatives of special interest groups to directly communicate their concerns to the state. Nevertheless, RIte Care would have benefited if these steps to involve stakeholders had started even sooner.

Most states have little direct experience in providing services through a managed care delivery system to low-income Medicaid beneficiaries. This was true for Rhode Island, making it a major challenge to create a statewide managed care system for the Medicaid population of families and children over a 1 -year period. Rhode Island brought in outside experts on managed care at all stages, using them for planning, implementation, and ongoing operations. This expertise was important in the development of the consumer education and enrollment efforts, as well as in the design of the quality assurance and encounter data systems. Other states may want to consider bringing in outside experts, particularly when existing Medicaid staff members have little managed care experience.

Large-scale Medicaid managed care initiatives have an impact on the health systems in states and can be expected to put stress on safety net providers. Four commercial MCOs in Rhode Island are participating in RIte Care, and more plans may bid to be part of RIte Care in the future. Two of the MCOs

had to develop primary care gate keeper products to take part in the demonstration, and one of these is in the process of obtaining approval to offer this new product commercially. Although the community health centers in Rhode Island were able to secure licensing for their own HMO (NHP-RI), concerns continue about the long-term viability of some of the community health centers. Some centers have had major problems (such as staff cutbacks and salary reductions). RIte Care's $10 per member, per month supplemental payments have not been enough for community health centers to make the needed transition from cost-based reimbursement to a fully capitated approach, especially given the state's growing uninsured population, RIte Care has done little to reduce the numbers of uninsured, with fewer than 1,000 enrollees qualifying under the expansion group provisions (compared with a projected increase of 10,000). Preserving the state's safety net of essential providers will be a major challenge for RIte Care, and other states can expect to face this challenge with a move to managed care.

Has Rhode Island's program increased primary care access? Prior to the demonstration, Medicaid fee-for-service payment levels were so low that many primary care providers did not participate in the state's Medicaid program, and emergency room use and inpatient hospital expenditures were inappropriately high. State officials believe that physician participation has improved dramatically under RIte Care, in part due to higher primary care payment rates and in part due to the state's mandatory mainstreaming clause. However, program data are not yet available to confirm whether significant changes have occurred in physician participation and emergency room use without any measurable loss in quality.

On the basis of Rhode Island's experience, states can expect a mixed reaction from providers regarding managed care. Those primary care physicians who worked in community health centers or the larger hospital clinics prior to the demonstration believe the quality of care for many enrollees will be adversely affected under RIte Care. They question whether private-practice physicians will be able to deal adequately with the range of medical and nonmedical problems many RIte Care enrollees face. On the other hand, private-practice physicians are generally positive about the change. In a physician focus group,

several said they severely limited their Medicaid participation prior to RIte Care. Their willingness to participate has now improved because the MCOs are paying them more, and they are paid more quickly than under Medicaid. However, physicians feel some frustration with the lack of patient education and understanding of the gatekeeper concept. They are also concerned about their ability to address the complex social, cultural, and language problems in the RIte Care population. Hospitals are generally unable to assess the impact of RIte Care on their operations yet, although several felt that emergency room use was declining.

Medicaid consumers are more positive about the move to managed care. Respondents in consumer focus groups expressed general satisfaction with their new arrangements under RIte Care. Many mentioned the stigma associated with Medicaid and welfare, and indicated that they saw RIte Care as moving the low-income population into the regular health care system, where they hoped there would not be as much discrimination. Their complaints relate primarily to general managed care procedures (particularly changes in their access to emergency services) and the poor reliability of RIte Care's automated enrollment verification system. Another indication of consumer satisfaction is that only 4 percent of enrollees elected to change plans during the first phase of an annual open enrollment period.

Rhode Island's experience (and that of the other states) suggests that moving Medicaid to managed care has widespread political support. RIte Care began under a Democratic governor, but the Republican governor who took office shortly after the program got under way has been committed to continuing the transition. His administration concluded the first year of RIte Care with a major review of program operations. At about the same time, the legislature held a series of six public hearings on RIte Care. In both instances, the reviews were undertaken with a positive focus on improving the program. Several mid-course corrections, which directly respond to concerns aired, are now in the planning stage. Other states might want to consider a similar performance review at the end of the first year, so that stakeholder groups can be heard and problems can be directly addressed where possible.

Finally, the first year of RIte Care confirms that Medicaid managed care seems to place stress on some service areas more than on others. As with managed care in other states, RIte Care is struggling with how to integrate mental health and nonmedical social services into a managed care system. Problems have occurred both with the process for obtaining access to these services and with the adequacy of the provider networks. In addition, controversy has continued over restrictions on access to emergency services, with concern that some RIte Care enrollees are now afraid to use emergency room services, even when appropriate. These service areas will be the focus of several changes in RIte Care, including a requirement that all MCOs contract with a network of social service providers, greater flexibility to MCOs in credentialing mental health providers, the imposition of hospital reimbursement for emergency room screenings, and a new definition of medical necessity.

IV. HAWAII'S QUEST PROGRAM

A. BACKGROUND FOR REFORM

Long before QUEST,' Hawaii was making innovations in health policy and striding toward universal health insurance coverage. In 1974, Hawaii enacted the Prepaid Health Care Act, which required that employers provide health insurance to full-time employees, not including dependents, part-time workers (less than 20 hours per week) and the self-employed (Friedman 1993; and Lenin and Sybinsky 1993).[2] Inspired by Washington State's Basic Health Plan, in 1989 the Hawaii Department of Health created a state-funded State Health Insurance Program (SHIP) designed to provide basic benefit coverage to the "gap group"--people not covered by the employer mandate or Medicaid (Hornbrook 1991). SHIP was available to people under 300 percent of poverty and charged sliding-scale premiums, although the enrollment was capped because of limited funding. Enrollment in SHIP was possible only during certain times of the year. SHIP offered either a limited benefit package or a Health Maintenance Organization (HMO) package. At its end in 1994, SHIP covered about 24,000 people. As a result of these policies, Hawaii had the lowest percentage of uninsured people in the nation.[3]

'QUEST stands for Quality of Care, universal Access, Efficient Utilization, Stable Cost, Transformation. These were goals for the new program.

'Hawaii is the only state in the union with an exemption from the federal Employee Retirement Income Security Act (ERISA) that otherwise prohibits states from employer mandates.

[3]On the basis of the pooled Current Population Survey (CPS) for 1990-l 992, the level of uninsurance among the nonelderly was 8.3 percent in Hawaii versus 15.8 percent for the nation; these data include Urban Institute edits of survey data to adjust for underreporting of Medicaid (Winterbottom et al. 1995). Since the CPS did not ask about participation in SHIP, it is possible that the true rate of uninsurance was lower, in the range of 4 to 6 percent. The CPS for 1994 now includes questions about state programs, like QUEST and SHIP, but a 1 -year sample is too small to be statistically reliable for Hawaii. A preliminary analysis of the new data for 1994 reports Hawaii's uninsurance rate was 11.6 percent, slightly higher than rates for Vermont and Wisconsin (Employee Benefit Research Institute 1996). However, the l-year estimates have not been edited to adjust for underreporting and probably have a large standard error.

The health care market in Hawaii also had unique features that shaped the development of QUEST. The Hawaiian health insurance market has been dominated by the Hawaii Medical Service Association (HMSA), the state Blue Cross/Blue Shield affiliate, which had 64 percent of the private market in 1992. Kaiser Permanente (a large group-model HMO) was also a major presence, with 19 percent of the market. Network-style capitated managed care was uncommon in the state. In addition, before QUEST, Medicaid was mostly fee-for-service. Medicaid enrollees could voluntarily join Kaiser's HMO, but only 5 percent of Medicaid clients did so.

This report is based on site visits and focus groups conducted in April and May of 1995 and the review of documents such as the demonstration application and quarterly reports. Where possible, we update the report with more recent information. We visited Honolulu, the capital and major urban area. To learn about rural issues, we visited the Kona area (west side) of the island of Hawaii, better known as the Big Island. The Big Island is the poorest county in the state and has the lowest overall concentration of physicians.

B. PROGRAM DESIGN AND IMPLEMENTATION

1. The Process of Design

QUEST was designed very quickly. Planning began in early 1993; the application was submitted in April and it was approved by July 1993. The program was formally implemented on August 1, 1994.

Soon after the November 1992 election of President Clinton, then-Governor John Waihee learned about the president's interest in expediting approval of federal waivers. The governor was interested in slowing the rate of Medicaid expenditure growth by integrating the services provided by three programs and using capitated managed care organizations (MCOs). Because the president requested that demonstration applications be completed by late April 1993, the Department of Human Services (DHS) worked quickly with consultants to submit an application by April 19, 1993. Some of the consultants were very familiar with Arizona's Medicaid waiver program, so this influenced the design of QUEST. After

federal-state negotiations, HCFA approved the waiver on July 16, 1993, making this the first of the new wave of Section 1115 waivers to be approved after the one in Oregon.

The rush of the demonstration program's development and approval caused some problems. A few groups, notably the Federation of Physicians and Dentists and the Hawaii Medical Association, felt that there had not been enough opportunity for public input and objected to the emphasis on managed care. At one point, the state senate threatened to block implementation of the program. Although the senate eventually acquiesced, implementation was delayed a couple of months.

2. Program Design

Many elements of QUEST were apparent from the first conceptualizations of the program. QUEST integrates three state insurance programs: (1) the nondisabled, nonelderly portion of Medicaid (primarily Aid to Families with Dependent Children [AFDC] clients); (2) General Assistance (GA) medical assistance; and (3) SHIP. GA and Medicaid were already jointly administered, although federal funds did not support medical assistance for GA adults.[4] QUEST brings all three programs together with consistent eligibility criteria and benefits, although sliding-scale premiums apply to upper-income beneficiaries. Acute medical care for disabled and elderly people and long-term-care services are still' administered under fee-for-service Medicaid, although there were plans to include medical services for the disabled and elderly in QUEST in the future.

QUEST benefits are provided by capitated MCOs, which are required to have primary care providers. Medical and dental plans are separated. The premium levels are determined in a managed competition framework, based on bidding by plans. The state did not try to enforce major savings in costs per person, compared to the level of Medicaid payments before, but hoped that capitation would slow the rate of future

[4]GA is the state-funded cash assistance program for poor people not categorically eligible for AFDC. In Hawaii, GA recipients must be temporarily disabled or meet work search requirements. GA recipients essentially received the same Medicaid benefits as AFDC-type clients, although without federal Medicaid match. Children in GA households were already eligible for federal Medicaid match as Ribicoff children.

rate increases. Since DHS had only dealt with one HMO before, it had to develop new contracting systems. The state issued requests for proposals for the medical plans to bid on in August 1993 and completed negotiations by April 1994. As will be discussed in more detail later, the state ultimately contracted with five medical MCOs and two dental MCOs (see Section F). DHS also developed bids and contracts for a behavioral health carve-out plan and reinsurance.[5]

3 . Startup

In May 1994, all AFDC-type Medicaid, GA, and SHIP clients were mailed notices that the programs were changing to QUEST and were asked to reapply and select MCOs. Enrollment for new clients also gradually began. The program officially began on August 1, 1994; MCOs became responsible for medical care on that day statewide. Some clients were confused during the mass enrollment period (for example, they were unsure which doctors participated in each MCO), so a grace period for plan switching was permitted on a one-time basis at the beginning of the program,

The implementation of QUEST within a year of HCFA approval can be viewed as an impressive achievement of the Med-Quest Division, the MCOs, and numerous other groups in the state. It required development of new systems and protocols in a short period of time. New Governor Ben Cayetano (elected in November 1994) and the legislature have been supportive of QUEST.

Some problems arose, at least partly because design and implementation were rushed. Three start-up problems frequently mentioned by state officials, providers and MCOs were:

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[5]The behavioral health "carve-out" plan is for people who are diagnosed as having serious mental illness. They receive care supervised by a separate MCO, featuring specialized case managers. A firm contracted by the state provides reinsurance for each MCO. The reinsurer is responsible for covering costs of care for patients whose costs exceed $30,000. Between $30,000 and $50,000, the reinsurer covers 50 percent of the cost and the MCO the balance. Between $50,000 and $1 ,000,000, the reinsurer covers 85 percent of the cost. Above $1 ,000,000, the reinsurer covers the full cost.

1. ***Enrollment Delays.*** ***Near*** the beginning of the program, it took 2 or more months to get an appointment for eligibility determination. In addition to inconveniencing clients, other problems resulted. Services were covered from the date of application (or up to 5 days before if there was a hospitalization), so delays in eligibility determination meant that it was not clear whether people were covered during tbis period and they had not yet been assigned an MCO. These delays led to confusion by patients, providers, and MCOs as to whether a given person was or was not covered in the gap period. Later in the year, the waiting time for appointments had fallen to 2 to 3 weeks. These problems were compounded by automated data processing (ADP) system shortcomings. The Hawaii Automated Welfare Information (HAWI) system was used for eligibility entry and transactions, but it was not designed for QUEST, nor was it under direct control of the Med-QUEST staff. A contractor is developing a new system designed for use with QUEST.

2. ***Some Disruption of Patient-Doctor Relationships.*** For various reasons (some inherent in managed care and some avoidable) a number of patient-doctor relationships were severed, and this might affect continuity and quality of care. Some doctors decided not to join a QUEST plan or, if they joined, wanted to sharply limit the number of QUEST patients. Clients sometimes joined plans that did not include their regular doctors or dentists. It was particularly difficult to know which specialists were in which plans. The state required that all members of a family be in the same MCO, so a mother might select a plan with her children's pediatrician but not her own gynecologist. Finally, clients often reported not being assigned to the primary care providers they requested, even if the doctor participated in the MCO; the reasons for the lack of assignment were not always clear.

3. ***General Communication Problems.*** Clients and providers also reported general difficulty in getting answers to initial operational questions. Telephone and fax lines to Med-QUEST offices or the MCOs were often busy and staff members often were unable to answer questions. In conjunction with enrollment delays and disruption of patient-doctor relationships, many clients and providers expressed frustration with the initial confusion. These problems appeared to have eased with time. Systems problems meant that the state and the MCOs did not always agree about who was covered and when. MCOs usually believed that their membership was larger than the state's estimates.

As the program entered its second year, a number of operational changes were occurring, including changes in eligibility criteria, premium levels, and contracts with MCOs; these are discussed later in this chapter

"Phase II" and possible federal budget cuts were two larger issues that affected QUEST. Phase II was the plan to extend QUEST managed care medical services to the elderly and disabled groups. As of May 1995, DHS was consulting with a number of groups to add the disabled and elderly to the managed care system. This would require a demonstration amendment application to HCFA (not submitted as of

April 1996) and probably be subject to state legislative review. Second, like all states in the nation, Hawaii was concerned about the possibility of large cutbacks in federal Medicaid funds or conversion to block grants. However, it was too early for the state to have specific plans on how programs might be modified.

C. PROGRAM FINANCING

The financial picture of QUEST has changed substantially between initial application and today. Table IV. 1 illustrates the budget estimates contained in Hawaii's application. Key elements of the original budget neutrality assumption were: (1) without reform, annual per capita expenditures would rise 10.5 percent per year; (2) under the demonstration, through managed care, inflation would be 6 percent per year; (3) children covered under SHIP were part of the baseline (without the demonstration) since they could be covered under a "hypothetical" Section 1902(r)(2) expansion;[6] and (4) the state's disproportionate-share hospital program (part of the baseline) would end.[7] In the aggregate, the state expected to keep federal payments about the same as before, but would reduce state expenditures by $429 million in 5 years.

The budget neutrality formula negotiated with the federal government was a "per-capita" formula. The state will determine the number of QUEST enrollees who were eligible under Medicaid rules, The federal grant will be the number of regular Medicaid-eligible enrollees multiplied by the average per-capita cost in fiscal year 1993, inflated by the actual changes in the Consumer Price Index for medical care for Honolulu plus 4 percent. The inflation rate was based on historical trends in Hawaii. Compared with those in other states, this was a generous budget neutrality agreement.[8]

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[6]The General Accounting Office (1995) has criticized the use of "hypothetical" assumptions in computing budget neutrality for these programs. It believes these increase federal expenditures.

[7]We were informed that hospitals often received disproportionate-share-related increases in the rates paid by MCOs instead, under QUEST.

[8]For example, Tennessee has a fixed budget cap, not based on the number of enrollees. Rhode Island also had a per-capita formula but used a lower inflation rate.

TABLE IV. 1

ORIGINAL QUEST BUDGET ESTIMATES
(Presented in Waiver Application of April 1993)

	Jan 1994-June 1994	July 1994-June 1995	July 1995-June1996	July 1996-June1997	July 1997-June 1998	July 1998-Dec. 1998	5-Year Total
Baseline[a]							
Unduplicated Enrollees		152,700	159,570	166,770	174,310		
Average Enrollees per Month	94,705	98,923	103,343	107,975	112,830	117,918	
Average Monthly Cost per Enrollee (in nominal dollars/month)							
Total (including administration)	$206.66	$228.29	$252.43	$279.39	$309.5 1	$343.16	
Expenditures (in millions of nominal dollars)							
AFDC-Related Medicaid	$66.5	$154.3	$179.1	$207.8	$241.2	$140.0	$988.8
General Assistance	$37.6	$88.1	$103.4	$121.4	$142.7	$83.9	$577.2
SHIP	$5.2	$11.4	$12.7	$14.1	$15.6	$8.7	$67.7
Administrative Costs	$8.2	$17.1	$17.9	$18.7	$19.6	$10.2	$91.6
Total Baseline Expenditures	$117.4	$271 .0	$313.0	$362.0	$419.1	$242.8	$1,725.3
QUEST							
Unduplicated Enrollees		151.400	159,540	168,180	177,340		
Average Enrollees per Month	99,628	105,025	110,755	116,840	123,306	130.177	
Average Monthly Cost per Enrollee (in nominal dollars/month)							
Medical Plan	$105.14	$112.45	$120.26	$128.62	$137.55	$147.10	
Dental Plan	$9.32	$9.98	$10.68	$11.43	$12.23	$13.09	
Total (including administration)	$174.98	$169.43	$179.65	$190.56	$202.18	$214.59	
Expenditures (ii millions of nominal dollars)							
Medical	$62.8	$141.7	$159.8	$180.3	$203.5	$114.9	$863.2
Dental	$5.6	512.6	S14.2	$16.0	$18.1	$10.2	$76.7
Mental Health	$10.6	$23.9	526.8	$30.2	$33.9	$19.1	$144.5
Catastrophic	$8.1	S17.7	$19.4	$21.2	$23.2	$12.7	$102.1
Administrative Costs	$17.5	S17.7	$18.6	$19.5	$20.5	$10.7	$104.4
Total QUEST Expenditures	$104.6	$213.5	6238.8	$267.2	$299.2	$167.6	$1,290.8
Difference in Expenditures							
Federal Share	($9.0)	(S2.9)	($0.2)	$3.2	$7.6	$6.6	$5.4
State Share	$21.8	$60.3	$74.5	$91.6	$112.3	$68.6	$429.1
Total	$12.8	$57.5	674.3	$94.8	$119.9	$75.2	$434 5

'Baseline assumes that GA and SHIP children are eligible for federal match. under Ribicoff and 1902(r) rules.

AFDC = Aid to Families with Dependent Children; SI III' -- State I lealth Insurance Plan.

Table IV.2 presents more recent budget estimates. Although we received this in April 1995, it was already clear that participation levels were out of date and underestimated. In both old and new budgets, total 5-year baseline expenditures were $1.7 billion, but the original budget estimated QUEST expenditures of $1.3 billion versus expected costs of $1.7 billion in the new budget. The net effect was that there would be almost no savings (or extra cost) for the federal government or the state.

Both participation levels and expected capitation payment levels were substantially higher than originally expected. The application budget assumed that average enrollment in state fiscal year 1995 would be 105,025 per month, but we were told in August 1994 that participation was estimated at 110,000 The April 1995 budget used an average level of 116,198, but the actual average enrollment was about 13 7,000. In the original budget, the average QUEST cost per enrollee (including administrative costs) was $169.43 for state fiscal year 1995, but the April 1995 budget estimated costs of $204.42 (excluding administrative costs).[9]

These differences, plus the additional costs of higher participation, have threatened the budget neutrality of the program. To the extent that higher caseloads are enrollees previously covered by SHIP or the GA adult programs, their costs must be offset by the savings on regular Medicaid enrollees. The state originally expected to reduce its expenditures for the state share of Medicaid by a great deal. The more recent budget problems pose a considerable hazard for the state. In principle, the state will be responsible for *all* expenditures beyond the levels permitted under the budget neutrality agreement, As of April 1996, budget neutrality estimates for the program's first year were not available.

As a result of these budget problems, the state changed policies twice to limit the size and cost of QUEST, after the date of our visit. First, effective August 1995, the state increased the premium share for those above the poverty level and made other eligibility changes. Effective April 1996, the state

[9]The average cost per enrollee included medical and dental capitation payments, reinsurance, and fee-for-service claims.

TABLE IV.2

REVISED QUEST BUDGET ESTIMATES AS OF APRIL 1995
(Excluding Department of Human Services Administrative Costs)

	August 1994-June 1995	July 1995-June 1996	July 1996-June 1997	July 199-k June 1998	July 1998-June 1999	5-Year Total
Baseline'						
Average Enrollees per Month						
AFDC Adults	21.279	23.726	24,201	24,685	25,178	
AFDC Children	47,777	53,271	54.337	55,424	56,532	
GA Children	3,548	3,903	3,981	4,061	4,142	
SHIP Children	13,479	13,854	14,131	14,414	14,702	
Total	86,083	94,754	96,649	98,582	100.554	
Average Monthly Cost Per Enrollee (in nominal dollars per month, based on 1993 costs)	$233.58	$260.09	$289.61	$322.48	$359.09	
Baseline Expenditures (in millions of nominal dollars)	$22 1.2	$295.7	$335.9	$381.5	$433.3	$1,667.6
QUEST						
Average Enrollees per Month	116,198	123,428	121,593	123,378	124,776	
Average Monthly Cost per Enrollee (in nominal dollars per month)	$204.42	$211.73	$227.06	$243.85	$261.46	
Total QUEST Expenditures (in millions of nominal dollars)	$261.3	$313.6	$331.3	$361 .0	$391.5	$1,658.7
Difference in Expenditures						
Total	($40.1)	($1 7.9)	$4.6	$20.5	$41.8	$8.9

'Baseline assumes that GA and SHIP children arc eligible for federal match, under Ribicoff and 1902(r) rules.

AFDC = Aid to Families with Dependent Children; GA = General Assistance; SHIP = State Health Insurance Plan.

imposed an asset test for QUEST and required full premiums for those above poverty. A new program was developed, QUEST-Net, to provide a more limited medical benefit to some of the people no longer eligible for QUEST or Medicaid. These changes are described more in the following section.

D. ELIGIBILITY AND ENROLLMENT

1. Eligibility Policy

To be eligible for QUEST, a person must be nondisabled, be under 65 years old, have income under 300 percent of the federal poverty guidelines, and not be covered under the insurance mandate of the Prepaid Health Care Act.[10,11] There were no assets tests prior to April 1996.[12]

Depending on one's perspective, QUEST provided either a marginal or major expansion of eligibility. Since SHIP already covered people up to 300 percent of poverty, QUEST covered relatively few people not already covered by preexisting programs. From the perspective of federally funded Medicaid, the QUEST expansion was quite large. Furthermore, in reality, SHIP caseloads were capped. Figure IV. 1 summarizes eligibility criteria among the three preexisting programs. Medicaid already had eligibility criteria that were generous by national standards. Those who voluntarily purchased private insurance (such as the self-employed or dependents) made up one group that was eligible for QUEST but not SHIP. In the first year, a person could be eligible for QUEST if he or she had voluntarily purchased private insurance (simultaneously or just before joining).

In the first year, those with incomes above 133 percent of poverty paid sliding-scale premiums. At the top end of the scale, the client pays all of the premiums (see Table N.3). To reduce participation

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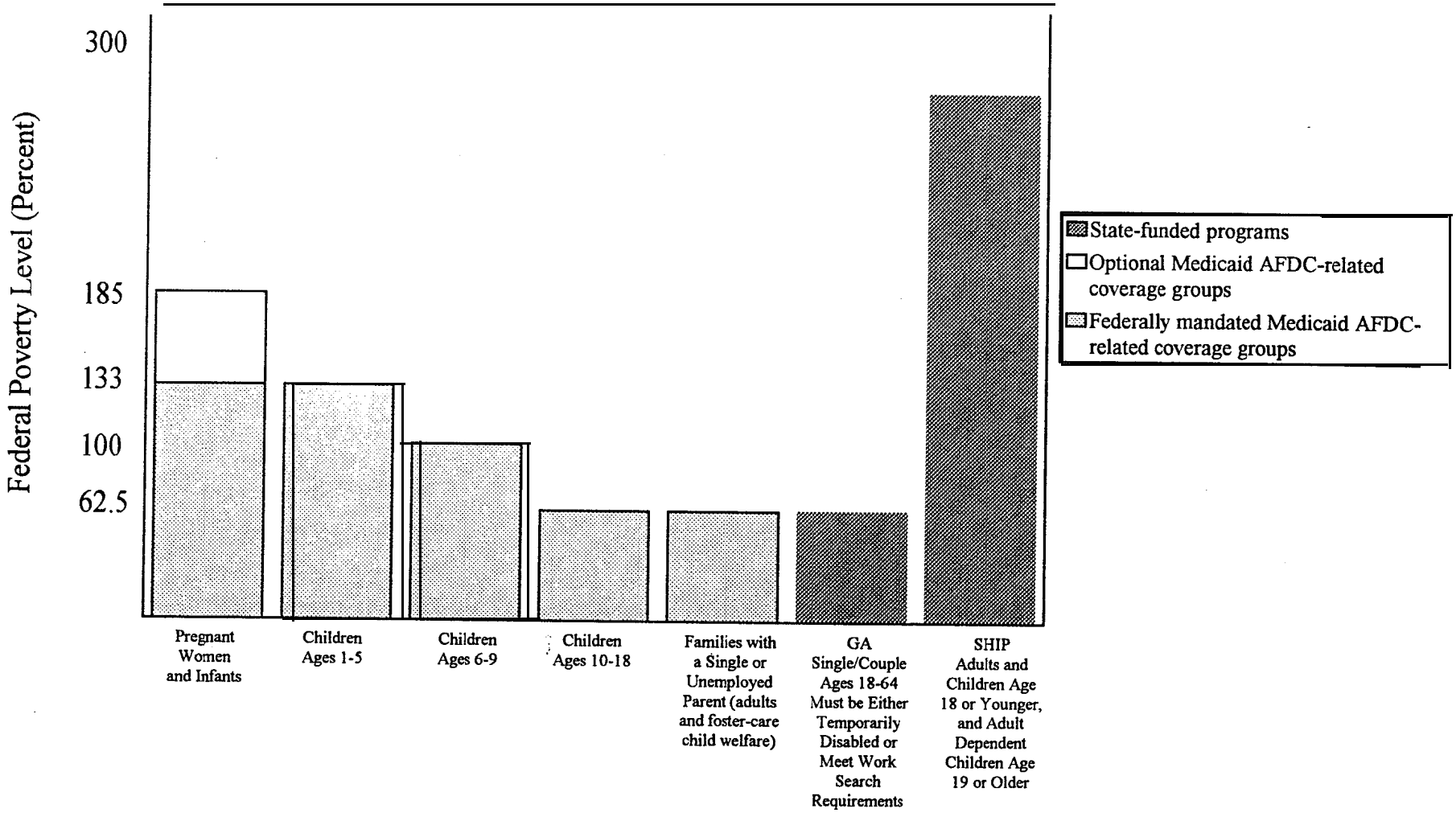
[10]Because of cost-of-living differences, the federal poverty guidelines are about 15 percent higher in Hawaii than in the mainland.

"Thus, full-time workers who must be covered by their employer are not eligible for QUEST, but their dependents (who are not covered under the mandate) are eligible for it.

[12]This discussion focuses on eligibility in the period before the major changes made in QUEST effective April 1996.

FIGURE IV.1

MEDICAID, GA, AND SHIP ELIGIBILITY IN HAWAI BEFORE QUEST



NOTE: Does not depict Aged, Blind, and Disabled. This category is excluded from the demonstration.

TABLE IV.3

PREMIUM SCHEDULE FOR QUEST FOR AN INDIVIDUAL FOR FIRST YEAR AND THE NEW SCHEDULE, EFFECTIVE AUGUST 1995 [a]

Family Income as a Percent of Poverty (Percentage) [b]	Year 1 Premium Share (Percentage)	Year 1 Monthly Medical Premium (Dollars)'	Year 1 Monthly Dental Premium (Dollars) [c]	Aug. 1995-March 1996 Premium Share (Percentage) [d]
100% or Less	0	$0.00	0.00	0
101 to 133	0	0.00	0.00	10
134 to 145	5	8.54	0.85	15
146 to 155	7	11.95	1.19	20
156 to 165	10	17.08	1.70	25
166 to 175	12	20.49	2.04	30
176 to 185	15	25.61	2.55	40
186 to 19.5	17	29.03	2.89	50
196 to 200	20	34.15	3.40	50
201 to 205	20	34.15	3.40	100
206 to 225	30	51.23	5.10	100
226 to 240	40	68.30	6.80	100
241 to 260	60	102.46	10.20	100
261 to 285	80	136.61	13.60	100
286 to 300	100	170.76	17.00	100

"The premium is the same for every family member, up to the fifth person. For example, a four-member family would pay four times these levels. Premiums for families with six or more members are capped at the five-person level. Poverty standards are the federal poverty standards for Hawaii, which arc 15 percent higher than levels for the mainland. For 1993-1994, 100 percent of poverty in Hawaii was $8,472 for one person and $14,808 for four persons.

[b] Except for pregnant women and infants under 1 year old up to 185 percent of poverty and others who were categorically eligible for Medicaid before QUEST, who do not pay premiums.

'The actual premium levels depend on the MCO selected and the island. The dollar premium shown for the medical plan is based on the HMSA plan for Oahu, which is the most common plan. The dental premium shown is based on the HMSA dental premium, since HMSA is the most common dental plan.

[d] The new rules were in effect August 1995 to March 1996. In addition, the self-employed must pay at least 50 percent of the premium, unless they were eligible for AFDC [in which case there is no premium). Effective April 1996, people with income above poverty paid full premiums.

levels, beginning August 1995, those with incomes above 100 percent of poverty were required to pay premiums, and full premiums began at 200 percent of poverty. The premium levels in Hawaii are relatively high: a family of four with full premiums would have medical premiums around $680 and dental premiums about $65 per month. In Year 1, only a small portion (about 5 percent) of the caseload paid premiums; most participants were below 133 percent of poverty. However, the premium changes could have a larger impact because a high proportion of the caseload was between 100 and 133 percent of poverty.

Other eligibility changes implemented August 1995 were:

1. Self-employed people were required to pay at least 50 percent of the premium. Eligibility staff believed that self-employed people sometimes hid income to get the lowest possible premiums.

2. Children under age 21 are deemed to have income from parents available to them. Some college students were declaring themselves as separate families with no income to get QUEST benefits for free, instead of paying regular health insurance premiums. This change is designed to keep middle-class families from dropping private health insurance for their children, particularly college students.

3. QUEST is prohibited to any worker offered health insurance, not including dependent children or spouses.[13]

Because of higher-than-expected participation and spending, and in response to a lawsuit filed by a disabled person, major changes were made in QUEST as of April 1996, with approval from HCFA. The state hopes that these changes will greatly reduce participation and expenditures. In this report, we do not focus on these changes but will examine them more closely in the 1996 site visit. The key changes include:

- QUEST imposed an asset test of $2,000 for a single person, $3,000 for two people, and $250 for each additional person. Pregnant women and children born after September 30, 1983, are exempt from the asset test.

[13]The initial exclusion was for those covered under the employer mandate. Thus, a part-time worker who was offered insurance by his employer was eligible in Year 1 but would not be eligible in Year 2.

- People with incomes above 100 percent of the federal poverty level must pay the full premium (the limit is above 185 percent of poverty for pregnant women and infants and 13 3 percent for children under age 6). Those with incomes below the poverty level still pay no premiums.

- People whose assets are too high for QUEST or who lose eligibility for Medicaid (aged, blind, and disabled people) may join a new program, QUEST-Net. Eligible people must have incomes less than 300 percent of the poverty level. There is a more generous asset test ($5,000 for a family of one, $7,000 for a family of two, and $500 for every additional person). Those with incomes above 100 percent of the poverty level must pay the full premium, but the QUEST-Net premiums should be less than half of the QUEST ones. The QUEST-Net benefit package for adults is much more limited: 10 inpatient days per year, 10 inpatient physician visits, 12 outpatient medical visits, limited prescription drugs, and emergency room visits only for emergencies and emergency dental services. There are modest copayments.

- Participation in QUEST-Net is capped at 40,000 people.

2. Enrollment Trends

The state originally anticipated that QUEST enrollment would be about the same size as enrollment in Medicaid, GA, and SHIP had been previously. As the program began, they expected an average monthly caseload of 110,000. As Figure IV.2 shows, enrollment quickly outstripped that projection and continued to rise, reaching more than 150,000 by May 1995. [14] QUEST staff believed that the growth was particularly strong among those just above the poverty level, who were previously ineligible for Medicaid. Although this demonstrates the popularity of the program, the growth also led to fiscal problems, including undermining federal budget neutrality

The reasons for the higher-than-expected participation are unclear. A statewide economic downturn is one reason. Between federal fiscal years 1993 and 1994, participation in the Food Stamp Program rose 11.3 percent; levels rose another 8.7 percent from 1994 to 1995 (Food and Consumer Service 1996).[15]

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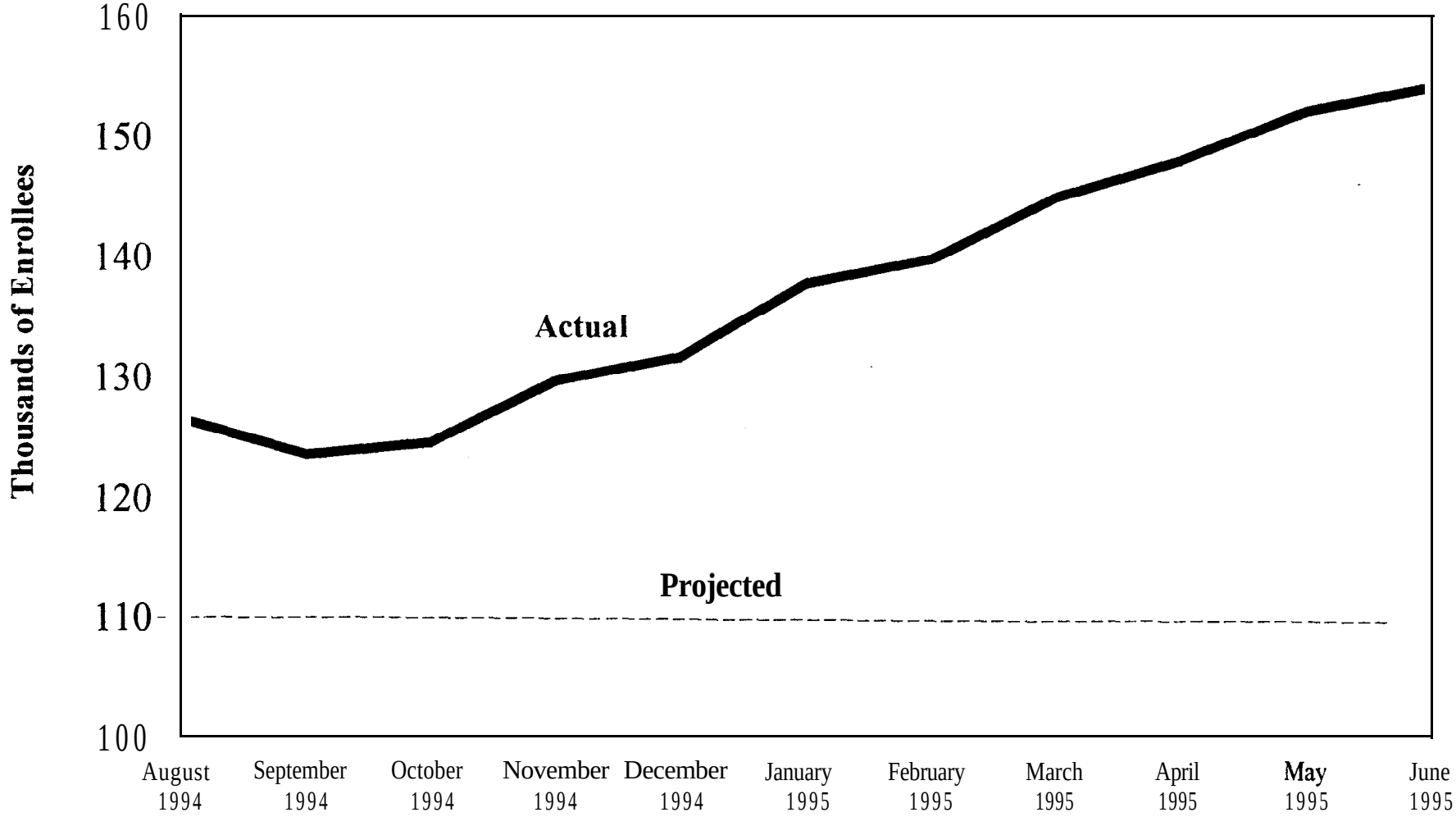
[14] For a number of reasons, including retroactive eligibility determinations, enrollment counts in QUEST are subject to fluctuations. We were also told that MCOs and the state did not always agree on participation levels.

'Since Food Stamp participation is relatively similar from year to year and across states, its participation levels are a quick approximation of changes in the poverty population. In contrast to Hawaii's levels, national participation rose 1.8 percent from 1993 to 1994 and then fell 3.1 percent from 1994 to 1995.

FIGU[illegible] IV.2

MONTHLY ENROLLMENT IN QUEST[a]



[a]Based on authorized eligible-months for medical plans.

The unemployment rate rose from 4.2 to 6.1 percent from 1993 to 1994; final 1995 estimates are not available yet, but provisional monthly estimates have continued in the range of 6 percent (Bureau of Labor Statistics 1995). It seems likely that the state also underestimated the number of uninsured people in the state. Finally, it seems plausible that QUEST was better advertised or easier to join than SHIP.

3. Eligibility Operations

In addition to changing eligibility criteria, the state changed the way eligibility is determined. A critical change is that eligibility determinations are now primarily the responsibility of Med-QUEST staff and are largely separate from welfare eligibility. If an individual applies for welfare, the welfare staff does an initial QUEST eligibility assessment, but final determination and selection of the MCO is the responsibility of Med-QUEST staff. A nonpublic assistance case is entirely the responsibility of Med-QUEST staff The Med-Quest Division had to hire new eligibility workers to handle these new responsibilities. Much of the enrollment backlog at startup was attributed to an inadequate supply of experienced staff members, caused by the changes in functional responsibilities and by general limits on state hires. After the program began, two important changes were made: the state designated a special unit to expedite certification of pregnant women, and arrangements were being made for outstationed eligibility workers at Federally Qualified Health Centers (FQHCs) and hospitals.

Certification periods are usually 1 year for nonpublic assistance cases. Welfare recipients are certified for 6 months to a year, depending on their AFDC certification period. Although the state does not guarantee a minimum period of enrollment, it tries to minimize churning due to brief administrative terminations from AFDC.[16] Even so, MCOs reported some problems with rapid turnover of cases.

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[16]Common reasons for AFDC termination are missing the eligibility appointment and lacking proper documentation. People who terminate for one of these reasons may reenter AFDC within a week or so, after the problem is resolved. This administrative "churning" of the caseload causes problems for MCOs that are told a case is dropped, then added again a few days later. Since the QUEST eligibility criteria are more generous than AFDC criteria, even the people dropped from AFDC are usually still eligible for QUEST.

As mentioned before, delays occurred in processing applications. The state policy covered eligible people from the date of application, which is particularly important for people with urgent medical needs. The state had planned for a 10-day "fee-for-service window," intended to cover the 10 days during which a person selected an MCO.[17] Administrative delays meant that the gap prior to plan selection could be lengthy, however, and delays after certification also occurred. Consumers told us it often took a month or two before they received their plan membership cards. To help fill the gap, DHS created a coupon system. The coupons indicated that a person had a pending QUEST application and that DHS would reimburse the claim for services rendered on a fee-for-service basis. The coupon system and fee-for-service window were not well understood by enrollees or providers, often resulting in confusion at the beginning of a spell on QUEST. Effective August 1995, the state changed this to clarify that the MCO is responsible only after eligibility determination and will only be paid capitation payments for that period; fee-for-service will apply before that time.

4. Enrollment Operations

An important new function for QUEST eligibility workers is enrolling new participants in an MCO. After a person is determined eligible, that person must select an MCO for his or her family. Each family selects a first- and second-choice medical and dental MCO. (Two choices are required in case the first plan is filled.) In each area of the state, enrollees have a choice of at least two medical and two dental MCOs.

Med-QUEST eligibility staff members offer relatively little education about how to select an MCO or what is required in managed care. In the first mass enrollment, the state distributed brochures, but personal counseling was not feasible. The state bars MCOs from door-to-door or similar direct marketing. Some marketing is done indirectly in providers' offices (for example, through posters or availability of

[17]For example, if a person selected Kaiser on the tenth day, Kaiser was to be responsible for fee-for-service claims for the first through tenth days prior to selecting Kaiser.

brochures about some plans). For new cases, some counseling may occur as part of eligibility determination; however, state rules require that any advice given by state staff be nonbiased, and Med-QUEST staff members are prohibited from recommending a specific plan. They may suggest that people choose the MCO in which their primary care doctor or dentist participates.

DHS auto-assigns people who do not select a plan within 10 days. The auto-assignment algorithm favors the least expensive plans." At the beginning, about one-third of enrollees were auto-assigned; by April 1995, this had fallen to about 10 percent. After medical and dental MCOs are assigned, QUEST clients receive new-member packages that include directories of primary care physicians or dentists. Clients must select primary care physicians or dentists within a certain period of time; otherwise, they are automatically assigned by the plan. Typically, the auto-assignments are providers available in or near the same zip code as the client,

In addition to the initial selection, there is an annual open enrollment period during which people may change plans. The first open enrollment season occurred during spring 1995, to be effective July 1995. Only 2,000 people (less than 2 percent of the total) changed plans at that time. The very low rate of plan switching could be interpreted as meaning that most QUEST enrollees were satisfied with their plans.[19]

Some clients and physicians expressed the belief that the state or the MCOs could have done a better job in advising clients about MCO choices or understanding the requirements of managed care. Some Medicaid programs assign more resources and make a more concerted effort toward consumer/patient education. One state official felt that the eligibility staff was too overburdened to provide much counseling; its principal objective is processing the backlog of applications.

"Because of the bidding mechanism, MCO capitation rates vary a little. (This is discussed further in Section F.) Since the QUEST premium structure is that a person of a given poverty level pays a certain percent of premiums, enrollees who pay premiums pay different prices for different plans.

'During the Year 2 open enrollment, the largest MCO, HMSA, was capped and not available as a choice to most people. If HMSA had been available as a choice, it is likely that more people would have switched plans (although the percentage is not known).

E. SERVICE COVERAGE

Hawaii's Medicaid program prior to QUEST covered a comprehensive range of services, including nearly all of the allowable optional services with few service limits. The range of services covered under QUEST also is broad and is based on the set of acute-care services offered under the fee-for-service Medicaid program.[20] Long-term-care services are not part of QUEST and continue to be provided on a fee-for-service basis under the remaining part of the Medicaid program. All medical MCOs must provide at least the standard benefit package: inpatient care, outpatient care, preventive services (including family-planning services), pregnancy and maternal care, emergency and ambulance services, nonphysician services, prescription drugs, vision care, and basic behavioral health services.[21,22] In addition to the medical services listed here, the state has encouraged (but not required) MCOs to offer a range of enabling services, including translation, education, and outreach. Dental care is provided by separate capitated dental MCOs.[23]

The most important difference in the benefits is for those previously participating in SHIP, which had a limited benefit package for those in the fee-for-service plan. Upon enrolling in QUEST, previous Medicaid and GA beneficiaries did not experience a significant change in covered services, while previous SHIP enrollees gained access to a far more comprehensive set of services.

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[20]Effective April 1996, QUEST services were limited somewhat and the QUEST-Net program was created. This section describes services before that date.

[21]QUEST enrollees age 18 and under are covered for eye examinations every 12 months. Older enrollees are limited to one eye examination every 24 months.

[22]MCOs may provide additional services, if there is no extra charge to the state or beneficiary. For example, during the second open enrollment period (held in May 1995), AlohaCare offered (with state and federal approval) a gymnasium benefit, MCOs may also limit certain benefits, such as use of name-brand prescription drugs. For mental health counseling services, some MCOs have allowed providers to determine the frequency and duration of visits on a case-by-case basis, given an overall service limit.

[23]Dental care for adults is capped at $600 per year, not counting emergency or nonpreventive care. There are no limits for children.

A second significant coverage change implemented in QUEST is the reduction of the retroactive benefit coverage. Under QUEST, retroactive coverage is limited to 5 days before application for inpatient or emergency care only. In contrast, standard Medicaid rules offered up to 3 months of retroactive benefits for all Medicaid-covered services.

A third modification to the predemonstration Medicaid benefit package relates to the creation of the behavioral health service managed care plan for the seriously mentally ill. While a range of basic mental health services are available to adults and children with moderate mental health problems, people with severe mental disorders receive behavioral health services through separate capitated plans under QUEST.[24]

Fourth, there may be some copayments under QUEST. Clients who pay premiums are also responsible for modest copayments for drugs ($2 for generic drugs and $5 for other drugs), emergency room use ($25 for nonurgent care and $5 for urgent care), and inpatient admission ($25 per admission). Those who do not pay premiums do not have copayments.

Finally, inherent under managed care, patients' use of services may be limited by requirements that primary care physicians and/or MCOs authorize specialty care, hospital admission, or testing. In general, providers in the MCO's network must provide care. However, the plans could make contingency arrangements for extremely specialized service needs.

F. MANAGED CARE PLANS AND CONTRACTING

This section first describes the characteristics of the MCOs in QUEST. Next it discusses them in the context of prior managed care. Finally, it discusses the contracting process and the state's role.

[24]The definition of serious mental illness does not include problems resulting from substance or alcohol abuse.

1. Summary of MCOs

Five medical MCOs--HMSA, Queen's Hawaii Care, AlohaCare, Straub, and Kaiser Permanente--submitted bids for the medical services portion of QUEST, and all were awarded contracts. Two dental plans--HMSA-Dental and DentiCare (of California)--successfully bid to provide dental care for QUEST enrollees. For behavioral health plans for adults, there was a joint bid from HMSA and Biodyne and a bid from Psychiatric Management Services.[25] The state only intended to award one contract; HMSA-Biodyne (together known as Community Care Systems) was the low bid. Tables IV.4 and IV.5 summarize the characteristics of the participating MCOs.

QUEST stimulated managed care within the state. One new medical plan (AlohaCare) was formed by the FQHCs, and DentiCare came to Hawaii through its QUEST bid. Queen's, Straub, and HMSA developed major new product lines and provider networks in response to QUEST. Other firms or providers were contemplating development of managed care bids for QUEST in the future. As discussed in the next section, many physicians were becoming involved in managed care for the first time through QUEST.

All of the medical plans are capitated and use primary care physicians as gatekeepers. Three MCOs (HMSA, Queen's, and AlohaCare) use physician networks, and two (Kaiser and Straub) use group model arrangements. All except Straub are nonprofit organizations.

- HMSA (the state Blue Cross/Blue Shield plan) is the largest plan by far, with almost two-thirds of total membership. HMSA also has the largest total panel of participating physicians, although (as seen in Table IV.5), it also has the lowest ratio of physicians to enrollees. Before QUEST, HMSA was the overall Medicaid state fiscal agent; it remains in that capacity for the remaining fee-for-service Medicaid program.

[25]The QUEST program contracted with health department providers to serve seriously mentally ill children enrolled in QUEST.

TABLE IV.4

HAWAII QUEST DEMONSTRATION CHARACTERISTICS OF MEDICAL MANAGED CARE PLANS

Name	Plan Type--QUEST	Enrollment Caps	Contracts with FQHCs	Geographic Area
Aloha Care	Not-for-profit Serves only QUEST	None	Yes, with all FQHCs	Oahu Big Island--East/West Kauai
Hawaii Medical Service Association (HMSA)	Not-for-profit Large insurance company with many product lines	DHS imposed cap at second open enrollment (some exceptions)	Yes	All Islands
Kaiser Permanente	Not-for-profit Group-model HMO Vertically integrated systems Has other product lines	Plan capped enrollment at 7,000 (soft cap)	No	Oahu Big Island--East/West
Queen's Health Systems	Queen's Hawaii Care Not-for-profit IPA Vertically integrated systems	None	Yes	All Islands except Lanai
Straub	For-profit Staff-model HMO Vertically integrated systems	Plan capped enrollment at 6,500	No	oahu Lanai

TABLE IV.5

HAWAII QUEST DEMONSTRATION CHARACTERISTICS OF MEDICAL MANAGED CARE PLANS

Name	Capitation Rates: Geographic Area	Year 1	Year 2	Overall Enrollment (6/95)	Total Number of Physicians in Network	Physicians per 1,000 Enrollees
AlohaCare	Oahu	$166.41	$164.50	20,624	240 PCPs	16 PCPs
	Big Island	$169.70	$165.50		212 Specialists	14 Specialists
	Kauai	$160.00	$160.00			
Hawaii Medical Service Association (HMSA)	Oahu	$170.76	$166.76	94,598	469 PCPs	6 PCPs
	Big Island	$157.28	$157.28		826 Specialists	10 Specialists
	Maui	$157.28	$157.28			
	Kauai	$157.28	$157.28			
	Molokai	$157.28	$157.28			
	Lanai	$154.28	$154.28			
Kaiser Permanente	oahu	$171.61	$167.61	7,998	119 PCPs	16 PCPs
	Big Island	n.a.[a]	$157.18		92 Specialists	13 Specialists
Queen's Health Systems	oahu	$155.56	$157.56	26.436	208 PCPs	10 PCPs
	Big Island	$144.82	$149.82		520 Specialists	25 Specialists
	Maui	$139.71	$142.71			
	Kauai	$145.69	$148.69			
	Molokai	$136.07	$139.07			
Straub	oahu	$171.00	$168.00	4,223	50 PCPs	16 PCPs
	Lanai	$154.65	$154.65		115 Specialists	37 Specialists
DentiCare	All Islands			46,697	69 PCDs	2 PCDs
	Adults	$15.68	$16.00		9 Specialists	.2 Specialists
	Children	'$8.29	$8.62			
Hawaii Medical Service Association (HMSA)--Dental	All Islands			103,780	243 PCDs	3 PCDs
	Adults	$17.00	$17.00		29 Specialists	.3 Specialists
	Children	$8.73	$8.73			

PCD = primary care dentist; PCP = primary care physician.

"Kaiser Permanente has no Year 1 rate because it did not apply to offer services on the Big Island that year.

- AlohaCare is an MCO formed specifically to bid for QUEST; it is an alliance between community health centers and clinics, which form the core of primary care providers. The University of Hawaii medical faculty are the core of specialists. Other doctors may also contract with the plan. As of mid-l 995, AlohaCare was third largest in QUEST enrollment.

- The Queen's Hawaii Care plan was formed in response to QUEST by the Queen's Health System, a loose, vertically integrated organization that owns a major Honolulu hospital (Queen's Medical Center) and a number of clinics. The Queen's Health System has a generous endowment to do charitable works.

- Kaiser Permanente is a major presence in Hawaii and also operates its own hospital in Honolulu. It is part of the national organization and acts as a group model HMO.

- Straub is primarily a large, for-profit, multispecialty practice in Honolulu, which also operates a hospital and large clinic. In QUEST it operates as a group-model HMO. This managed care plan was formed for QUEST and is one of the few insurance products that it offers.

HMSA also operates a dental plan and the behavioral health plan. Many of its dental services are provided through dental clinics that it owns throughout the state. The final MCO is DentiCare, a California-based organization (a subsidiary of Foundation Health Plan) that came to Hawaii explicitly to bid for QUEST, and developed networks of dentists for QUEST.

2. Managed Care in Medicaid

The implementation of the QUEST program, with its emphasis on managed care, represented a significant departure from the conventional, fee-for-service-based health care financing and delivery systems that dominated both the Medicaid program and the Hawaiian health care market in general. Prior to QUEST, the Hawaii Medicaid program had limited experience with managed care. Medicaid enrollees were permitted to enroll in a managed care plan on a voluntary basis. At that time, Kaiser Permanente, a staff-model HMO, was the one managed care plan available to Medicaid enrollees. Most Medicaid beneficiaries (about 95 percent) opted to use fee-for-service medical care. The SHIP program also used the Kaiser Permanente plan for a portion of the enrollees; however, roughly 80 percent of SHIP participants were enrolled in an indemnity plan. Overall (mostly private) HMO membership in Hawaii was 23 percent, higher than the national average of 16 percent in 1992 (Group Health Association of America

1993). Most managed care was concentrated in the group-model Kaiser Permanente HMO; Independent Practice Association (IPA) or network-type managed care was uncommon before QUEST,

The QUEST program initiated widespread use of managed care to emphasize preventive and primary care and control inflation. Under the demonstration, all acute medical and dental care services are provided under capitated payment arrangements with MCOs, which were selected using a managed competition model.[26] At a minimum, all plans are required to employ a "gatekeeper" model of managed care. The primary care physician must authorize most specialty care, laboratory tests, and hospital admissions; sometimes the MCO must also authorize care. The specialist, laboratory, or hospital to which the patient is referred usually must be part of the MCO's contracted network.

Managed care in QUEST was not highly regimented; for example, most of the care was provided in network plans and the MCOs did not use extensive practice guidelines. However, QUEST appears to be serving as a significant stimulus to the evolving managed care market in Hawaii. Both the health insurance companies and providers are gaining the experience and developing the systems needed to successfully operate in a managed care setting. For instance, many physicians and dentists have been exposed to primary care gatekeeper roles and referral processes for the first time. In addition, as a result of QUEST, a new MCO (AlohaCare) and an out-of-state managed care plan (DentiCare) have entered the health insurance market. Existing health insurers developed significant new managed care product lines in response to QUEST. Some of these companies hope to use the managed care experience gained from the QUEST program as a basis for competing in the managed care market outside of QUEST. It seemed

[26]That is, plans were selected through competitive bidding, with the terms of the competition and selection limited by state-established rules. For example, the state established rules on benefits, marketing, and risk adjustment.

likely that, if bidding were opened in 1995, at least two more MCOs would be willing to bid for QUEST business because of the enhanced visibility of managed care in the state.[27]

3. QUEST Contract and Policy Management

a. The Bidding Process

For the first contracting period, the procurement process that DHS used in selecting MCOs to serve the QUEST population essentially followed standard competitive bidding procedures.[28] Three separate requests for proposals (RFPs) were issued by DHS for medical services, dental care, and the behavioral health carve-out for the seriously mentally ill. The RFP for medical services was issued in August 1993 In the following months, medical and dental MCOs submitted proposals, including estimated capitation rates; DHS (with assistance from consultants) then evaluated the proposals and negotiated with plans. It awarded contracts in April 1 994.[29]

The state did not restrict the bidding process to certain types of MCOs or to in-state plans, although there were some basic structural and financial solvency requirements. State certification was not an issue in Hawaii, because the state does not regulate health insurance companies. The state also received a waiver of the "75-25" rule that prohibits MCOs participating in the standard Medicaid program from having a greater than three-to-one ratio of Medicaid or Medicare to private enrollees; as a result, under QUEST, MCOs were no longer required to have a minimum level of commercial clients.

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[27] According to interviews with hospital staff, Kapiolani Medical Center planned to develop its own MCO and enter the next round of bidding. The Hawaii Dental Service, an insurer offering both medical and dental insurance, was also contemplating bidding in the upcoming contracting period.

[28] The original contract period for medical, dental, and behavioral health plans was approximately 2 years. The state recently extended the contract period another year (through June 1997), to have the next round of negotiations coincide with the planned startup of QUEST Phase II--the expansion of the QUEST program to Supplemental-Security-Income-related Medicaid populations. However, just as it did this year, the state may renegotiate certain aspects of the contracts prior to their expiration.

[29] An RFP process was also held for the reinsurance plan, which was awarded to Anthem.

The state was divided into regions; except for the Big Island (which was divided into east and west sides), these regions corresponded with an island. Plans bid to provide services in each region, with separate capitation rates. Plans were also allowed to limit the number of QUEST recipients that they wished to serve. Dental plans and mental health plans were required to bid for the entire state. The RFPs did not regulate contracts between bidding organizations and any subcontracts they executed. Thus, the state was not involved in negotiations between MCOs and providers (such as hospitals, health centers, pharmacies, and physicians). MCOs were encouraged to contract with FQHCs but could opt out if they could demonstrate that they had adequate capacity to care for patients without the FQHCs.

b. Actuarial Analyses

To assist MCOs in estimating capitation rate bids, DHS provided bidders with historical (1993) utilization and demographic data on the Medicaid, GA, and SHIP populations. The MCOs were instructed to incorporate copayments and reinsurance arrangements in setting their rates. DHS also provided bidders with case mix risk adjusters used by the state's actuaries in estimating a range of acceptable rates. These risk adjusters--multipliers used to gauge the relative costs of different groups of participants--varied by age, sex, and basis of eligibility (AFDC, GA, Foster Child, or SHIP). Actuarial data suggested that GA enrollees in Medicaid had been the least healthy group of Medicaid enrollees and also had incurred the highest costs. Medicaid enrollees appeared to be slightly more expensive than SHIP enrollees.

c. **Negotiations**

Before entering into negotiations with an MCO, the state first screened each plan's proposal for three criteria: (1) administrative capacity, (2) fiscal stability, and (3) quality of care (for example, sufficient provider networks, quality assurance teams, medical director). All five medical MCOs, the two dental managed care plans, and two behavioral health plans satisfied the criteria and proceeded to negotiate with the state.

The primary point of discussion concerned the differences in the assumptions used by the state and by each MCO to develop capitation rates. Initially, all of the medical plans proposed capitation rates above $200 per member per month for the island of Oahu. This rate was considerably higher than the state's maximum acceptable rate per member, per month for Oahu residents. After initial negotiations, the medical plans' capitation rates ranged from $156 to $176.[30]

Although the major point of discussion during negotiations was the capitation rate, the state and MCOs also negotiated on other contract terms. For example, because the AlohaCare plan was formed in response to QUEST and consequently (unlike the other MCOs) had no private-sector business, the state made an exception in its performance bond requirement and allowed AlohaCare to secure a bond worth 1 month (instead of 2 months) of capitation payments.

d. Changes for Year 2

Two important changes transpired as the state moved into its second year. First, the state (with acquiescence from HCFA) decided to cap enrollment for the largest MCO, HMSA, during the open enrollment period. This was intended to ensure that the other plans had enough membership to stay viable and competitive. Second, it was expected that capitation rates for MCOs would be automatically increased in the second year, with the increase pegged to the Consumer Price Index. Instead, the state decided to renegotiate capitation rates with MCOs, because of state budget restraints and because state analysis of MCO financial reports indicated that participating plans were faring well financially. The resulting Year 2 rates typically decreased capitation rates by $2 to $4 in Oahu, the major population center. For example, HMSA's rate dropped from $171 per month in Year 1 to $167 a month in Year 2. The Queen's rate,

[30]These rates were bid assuming an average distribution of risk among clients. However, the actual rates paid by the state are modified on the basis of risk adjustment multipliers based on the case mix for each plan's enrollees. The multipliers are based on the age, sex, and basis of eligibility (AFDC, GA, Foster Child, and SHIP). The multipliers are based on prior fee-for-service differences in the cost of serving different types of people. In general, GA clients are more expensive.

previously the lowest, was increased slightly.[31] All but the lowest-paid plan reduced rates slightly. A similar renegotiation process was held for the two dental plans.

e. Quality Assurance/Improvement

Since there are no general state licensing laws for HMOs, the responsibility for regulating QUEST plans falls primarily on DHS. Under QUEST, the state plans to continually monitor MCOs' performance through mandatory MCO reports to DHS, on-site management reviews of MCOs by DHS staff, quality-of-care audits by an external quality review contractor, consumer surveys, and analysis of internal state data. Under the direction of the QUEST medical director, the state is developing standards on the basis of encounter data and HEDIS reports that will be used to monitor care. The state is in the process of developing the new system to monitor the quality of care provided by MCOs.

G. PROVIDER RELATIONS AND PARTICIPATION

1. Physicians

a. General Views

Prior to the implementation of QUEST, managed care primarily meant Kaiser Permanente; network-style care was uncommon. QUEST often was the first exposure of many independent doctors to gatekeeper roles or limited networks. Many physicians have serious misgivings about QUEST, but many of these are concerns about managed care, for which QUEST is seen as the harbinger. A physician survey conducted on behalf of the Hawaii Medical Association indicated that a majority of respondents were

[31]The most recent contract modifications also appear to have resulted in the Kaiser Permanente plan becoming available on the Big Island. Originally, Kaiser had bid only for Oahu and had been participating as a primary care provider through the Queen's Hawaii Care plan on the Big Island.

unhappy with QUEST (Budde 1995). Some of the concerns expressed by physicians or physician organizations, mentioned in interviews and a focus group, include:[32]

- Perhaps the greatest concern was that managed care involved more hassles. Physicians believed that they faced more administrative barriers but were not receiving extra compensation for the additional costs of practice.
- Physicians often lost many preexisting patients, while gaining many new patients; this disrupted doctor-patient relationships. They viewed the patient assignment process as haphazard.
- It was often difficult to communicate with the MCOs, particularly in the beginning when physicians had the most operational questions.
- QUEST enrollees were not receiving an orientation to managed care and the gatekeeper concept; thus, they often continued nonurgent use of the emergency room.
- Statewide, there were concerns about whether MCOs had enough of certain specialties or subspecialties, such as neurologists or pediatric endocrinologists.
- Many felt there were not enough primary care physicians or even basic specialists (for example, general surgeons) in the rural area (Kona).

In spite of these concerns, physicians normally stated that they had not substantially changed the way they practiced medicine (except for changes in authorization processes).

b. Participation

An important difference between Hawaii and Tennessee and Rhode Island was how physicians contracted with the MCOs. In Hawaii, contracting with a QUEST MCO was completely voluntary (except for staff physicians in staff-model HMOs or certain clinics that joined QUEST on an institutional basis); agreement to serve QUEST patients was independent of treatment of commercial patients for the same company. By contrast, in both Tennessee and Rhode Island, physicians in some existing networks were

[32]A focus group of QUEST primary care physicians practicing in Honolulu was conducted to gain a better understanding of physicians' reactions to QUEST and to managed care. For a detailed description of the focus group meeting, see Appendix C.

required to accept demonstration participants. We were informed that some doctors who used to treat Medicaid patients did not sign QUEST contracts. This difference increases the importance of determining if enough doctors joined the QUEST MCOs.

At this stage of the project, we do not have definitive data to compare physician participation levels in Medicaid and in QUEST. Such an analysis would require analyses of provider files, claims and encounter data, or survey data. However, our impression is that, at the time of our analysis, somewhat fewer physicians contracted with QUEST plans than participated in the predemonstration Medicaid. It seems plausible that many of those who did not contract provided little Medicaid care, so that it is not possible to say if this had much of an impact on access to medical services.

Since MCOs use a limited panel of providers, it is useful to measure whether enough doctors participate. A rough assessment of the adequacy of physician participation was possible using provider lists that the MCOs supplied. Table IV.6 presents data on the number of physicians participating in QUEST plans, unduplicated across plans. [33] The data indicate that between 46 and 55 percent of primary care physicians and 81 percent of specialists in Hawaii participate in at least one QUEST plan.[34]

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[33]The accuracy of these estimates depends on the reliability of the provider lists. Our estimates would be inaccurate if these lists include physicians who have contracted with, but do not actually see, QUEST patients, or if other physicians have contracted with the MCOs since the lists were produced. We estimated the number of unduplicated physicians who participate in multiple MCOs or in multiple practice arrangements. Primary care physicians include those in general and family practice, internal medicine, pediatrics, and obstetrics/gynecology. The definition of a primary care physician may vary across MCOs. Some physicians may serve as both primary care physicians and specialists (for example, obstetricians/gynecologists). The estimation process involved sampling physicians from each plan and counting duplication with other plans. Since the estimation process was based on sampling, the unduplicated counts are not exact, but they should be reasonably close.

[34]The denominators for physicians come from data from the 1993 American Medical Association master file, based on the number of patient care doctors (American Medical Association 1993). For primary care physicians, we include family and general practitioners, internists, pediatricians, and obstetricians/gynecologists; specialists are all other physicians. Because some internists and obstetricians/gynecologists are only available as specialists, the percentage of participating primary care physicians may be somewhat underestimated and the percent of participating specialists overestimated. For primary care physicians, we use two denominators: the total number of patient care primary care physicians (as defined above) and the number of office-based (that is, not hospital-based) primary care physicians. For specialists, we use the total number of patient care physicians, regardless of practice site.

TABLE IV.6

PHYSICIAN PARTICIPATION RATES IN QUEST

Overall State of Hawaii	
Primary Care Physicians	
Total unduplicated primary care physicians in QUEST	560
Primary care physicians per 1,000 enrollees	3.6
Total patient care primary care physicians in state (1993)	1,220
Patient care primary care physicians participating in QUEST	46%
Total office-based patient care primary care physicians in state (1993)	1,011
Office-based primary care physicians participating in QUEST	55%
Specialists	
Total unduplicated specialists in QUEST	1,070
Specialists per 1,000 enrollees	7.0
Total patient care specialists in state (1993)	1.313
Patient care specialists participating in QUEST	81%
Big Island (Hawaii)	
Primary Care Physicians	
Total unduplicated primary care physicians in QUEST	81
Primary care physicians per 1,000 enrollees	2.2
Specialists	
Total unduplicated specialists in QUEST	115
Specialists per 1,000 enrollees	5.9

NOTES: The number of physicians is based on lists of available physicians provided by MCOs. Enrollment is based on June 1995 QUEST participation.

Expressed differently, there were 3.6 primary care physicians and 7.0 specialists per 1,000 QUEST enrollees (based on June 1995 enrollment). On the Big Island (the rural area we visited), there are relatively fewer physicians: the ratio of primary care physicians per 1,000 QUEST enrollees was 2.2, and the ratio of specialists was 5.9.

To the best of our knowledge, there are no clear standards for the minimum level of physician participation in programs such as QUEST. The HCFA review guide used to review Section 1115 applications suggests that a minimal standard used in Section 1915(b) programs is 1,200 to 1,500 clients per physician (Health Care Financing Administration 1995a). Under this standard, QUEST had an ample supply of doctors in QUEST statewide, as well as on the Big Island. However, numerous sources reported problems of insufficient physician participation on the Big Island. For network-type MCOs in which physicians see a mix of QUEST (or Medicaid) and other patients, we believe a more realistic standard is 1 primary care physician per 400 to 600 enrollees, or 1.7 to 2.5 primary care physicians per 1,000 enrollees.[35] By this standard, QUEST had enough primary care physicians statewide, but primary care physicians were somewhat low on the Big Island. Physician-to-enrollee ratios are not the best method of measuring adequacy of physician participation; average appointment waits or travel time are better measures, but these data are not yet available.

In general, our discussions with doctors and enrollees did not indicate widespread access problems, although respondents mentioned problems in the rural area we visited and statewide problems for some specialties or subspecialties (for example, neurologists). The data shown here are consistent with the perception of broad adequacy and shortfalls in some geographic areas. Some of these problems may also

[35]A common staffing standard for primary care physicians in HMOs is 1 primary care physician for every 2,000 members (Dial et al. 1995). However, in networks, participating physicians generally limit the proportion of total patients from one plan or from Medicaid. If we assume that an average primary care physician will take 20 to 30 percent of his or her total patient caseload from Medicaid, then this yields a ratio of 1 primary care physician to 400 to 600 Medicaid/QUEST enrollees. MCOs whose physicians serve a higher proportion of Medicaid clients (for example, MCOs relying on community health centers) would need fewer doctors per 1,000 Medicaid/QUEST enrollees.

have occurred in predemonstration fee-for-service Medicaid, so it is not possible to say whether access has changed because of the conversion to managed care.

c. Payment Methods and Levels

Prior to QUEST, the state's 1993 Medicaid physician payment rates were 86 percent of the 1993 national average (Norton 1995a). The physician payment rates did not change drastically with the implementation of QUEST. In general, physicians did not state that the level of reimbursement under QUEST was a disincentive to participate in and of itself Instead, reimbursement rates were viewed as too low because of the additional administrative duties required under managed care.

The five medical managed care plans maintain numerous payment arrangements with their physicians. Kaiser and Straub, the two closed-panel HMOs, primarily use salaried physicians. We did obtain a broad picture of how the three network plans (HMSA, Queens, and AlohaCare) paid physicians, although it was not possible to identify actual payment rates.[36] HMSA, the largest network, offered primary care physicians a choice of being paid through fee-for-service (at Medicaid rates), capitation, or a mixed method (fee-for-service within a predetermined budget). About a third of the physicians and two-thirds of the dentists had capitated arrangements with HMSA; the plan hoped that these proportions would increase over time. In many cases, capitated physicians were members of group practices that could spread the risks further. Queens, the second largest plan, reported that about three-quarters of its primary care physicians were capitated, while the rest received fee-for-service payments that were about five percent above the old Medicaid rate. AlohaCare supposedly had the most generous physician payment levels. The system of risk-based capitation was relatively complex. Primary care physicians were capitated for

[36]We asked each of the five medical MCOs to complete a short, confidential questionnaire that described payment methods and rates, but only two plans agreed to do so, In general, MCOs viewed payment methods and rates as proprietary data that they were unwilling to divulge. Like many state Medicaid agencies, DHS viewed payment methods and rates as internal management decisions of their contractors.

primary care services but participated in shared risk pools for payments to specialists, hospitals, and ancillary services. Since many of Aloha&e's primary care physicians come from FQHCs, the health centers accepted the capitation rates and assumed the related risks. AlohaCare's physician fee schedule was based on the Resource-Based Relative Value Scale. Our impression was that specialists were typically paid on a fee-for-service basis in all three network MCOs.

2. Hospitals

a. General Views

The hospitals were relatively neutral about QUEST. Our meetings with hospital representatives and associations in April and May suggested that the hospitals had adopted a "wan and see" approach to QUEST. A few minor complaints about initial implementation problems and reimbursement delays were voiced. Generally, our impression was that there had not been enough time for hospitals to assess whether or not Medicaid-related patient volume or revenues had declined. Since the program began in August 1994, the hospitals had accumulated little data on the impact of QUEST, because hospital claims are often processed months after services have been rendered. At the very least, they were not aware of dramatic changes in inpatient volume or emergency room use or of any hospitals being severely affected by QUEST.

The unique nature of Hawaii's hospital market also may have contributed to the hospitals' relatively cooperative attitude concerning QUEST. There are no for-profit hospitals in the state; all hospitals are either state-owned or nonprofit. In Oahu, the nonprofit hospitals are dominant, and state hospitals provide specialized care (such as rehabilitation services). On the neighbor islands, state-owned hospitals are often the major community hospitals and figure more prominently than on Oahu. Unlike in most states, there is little excess bed capacity in Hawaiian hospitals; the occupancy rate is 83 percent, compared with 69 percent for the nation (American Hospital Association 1993). Through planning and/or consensus, different hospitals have developed expertise in different areas: Kapiolani is known as the maternity and

children's hospital, Queen's Medical Center specializes in trauma cases, Straub is the bum center, and St. Francis specializes in organ transplants.

b. Participation

Neither hospitals nor MCOs seemed to be discriminating in executing contracts; most hospitals were participating in most QUEST provider networks. The exceptions were the closed-panel HMOs, Kaiser Permanente and Straub; the Kaiser hospital accepts only QUEST enrollees participating with Kaiser, and Straub largely limited its hospital to Straub/QUEST enrollees. As the prominent bum center, Straub Hospital would see QUEST patients from other plans, under appropriate circumstances. Each MCO also recognizes the possibility that, if specialized services are needed, patients might be flown from a neighbor island to Oahu or to a mainland hospital for care.

According to some interviewees, MCOs (at least in the preliminary stages of QUEST's implementation) did not want to contract selectively with hospitals or to upset established physician-hospital relationships. Thus, there was relatively little steering toward low-cost hospitals, although this is a standard means of saving money in managed care.

c. Payment Methods and Levels

Hospitals reported that payment rates were similar to those under the predemonstration Medicaid program and that they had established a variety of payment arrangements with MCOs. Hospitals' negotiating experiences varied (depending on the type of hospital), although most hospitals felt they had little negotiating power over payment rates. The Department of Health (DoH) negotiated jointly for all state hospitals. Some state hospitals might have benefited by leveraging their positions as the only hospitals on a particular island to get higher payment rates; however, the DoH approach did not allow for this.

It was not clear whether the discontinuation of the disproportionate-share hospital program (and the related provider tax) caused financial problems for hospitals. One large hospital noted that, in negotiating payment rates with MCOs, it simply incorporated existing disproportionate-share funds into the per-diem rates under QUEST.

Payment mechanisms also varied across hospitals. For instance, the dominant QUEST medical MCO, HMSA, continued to pay hospitals (plus ancillaries) on a per-diem basis, while AlohaCare and Queen's Hawaii Care paid all-inclusive per diems. Some hospitals entered into new financial and risk-sharing arrangements. AlohaCare included hospitals in the risk pool for hospital services, so that hospitals (in conjunction with physicians) could gain from lower hospital costs.

3. Federally Qualified Health Centers and Public Health Services

As in other states, FQHCs in Hawaii were concerned that MCOs would not always include health centers as providers and that their new payment rates would be less than cost-reimbursement assured by FQHC legislation.[37] To deal with the first problem, they formed their own MCO, AlohaCare, which includes health center directors on the board of directors. In addition, both HMSA and Queen's contracted with most FQHCs in the state. Nonetheless, the FQHCs (one large center in particular) 'received less under QUEST than under cost-reimbursement. The state had agreed, in principle, to make up the difference; at the time of our visit, however, it had not been able to secure all the funds. A third issue for FQHCs was whether the state would pay for outstationed QUEST eligibility workers to help enroll eligible people who come to the health center for service. The state planned to issue a contract to pay for this service.

Public health providers had a slightly different set of concerns centered around who was responsible for providing certain services and who would pay. DoH provides or underwrites early intervention services

[37]Essentially, Medicaid law entitles health centers designated as FQHCs to receive payments on the basis of the actual cost of providing services. Although the Section 1115 terms waived the requirement that FQHCs be reimbursed on a cost basis, there was interest in trying to support the FQHCs.

for children at risk, mental health services for seriously emotionally disturbed children, and health services for developmentally disabled children. DoH historically billed Medicaid for all services rendered to Medicaid enrollees; they were not always in MCO provider panels, however, and the MCOs did not necessarily believe that certain benefits were in their scope of service. This led to confusion and to antagonism between the MCOs and DoH. For instance, MCOs referred a number of speech and physical therapy cases among QUEST patients to DoH providers, expecting that DoH funds would pay for care. The DoH providers felt they should be compensated by the MCOs. They also worried that the MCOs did not have the right specialists in their panels. At the time of our interviews, the medical and financial responsibility for caring for providing services traditionally rendered by DoH was being negotiated.

At a broader level, both FQHCs and public health providers worried that managed care threatened the viability of their services, which they had built up over years as the traditional providers of health care to the uninsured and low-income populations. In addition, they worried that private physicians might not be as well suited to the needs of disadvantaged populations, so that their target populations might be jeopardized. DHS was trying to be attentive to their needs, but more time will be needed to assess the impact for these providers.

H. CONSUMER VIEWS

To leam about participants' experiences with the program, we convened three focus groups: (1) an urban group of general QUEST clients and uninsured low-income people in Honolulu, (2) a group of QUEST clients with chronic health problems, and (3) a rural low-income QUEST and uninsured group. Appendix D provides a more complete summary. We spoke with 23 people: 18 QUEST clients, 2 former QUEST clients, and 3 uninsured people.[38] Ten were members of the chronically ill group, although a few

[38]There was a surprising level of diversity in insurance patterns within the households of respondents. Many QUEST households also include privately insured or uninsured people. For example, a child might be on QUEST, while the mother is uninsured and the father privately insured.

people in other groups had chronic problems.[39] The focus group discussions, although illuminating, should not be interpreted as representing a statistically valid cross-section of QUEST clients or other low-income people.

Two general observations can be made. First, most focus group respondents said they were relatively satisfied with the medical care they received in QUEST (that is, the care provided by contracted doctors or nurses). They were slightly less satisfied with the MCOs and the administrative features of QUEST, although most were satisfied or somewhat satisfied. Second, the chronically ill group was less satisfied with medical care and administrative features than the low-income groups. The chronically ill were more concerned about reduced access to specialists or emergency care. Furthermore, since they use more medical care, they were more likely to encounter administrative problems (such as problems getting referrals).

1. Administrative Problems

Many of the complaints concerned the administrative procedures of Med-Quest Division or the MCOs. Some mentioned the delays in getting eligibility appointments or in getting their MCO membership cards. After enrollment, many felt that they were not given much education or counseling about how to select an MCO or what managed care entailed. While many had no problems, many others were puzzled or frustrated by the administrative changes and procedures.

On the positive side, respondents usually mentioned that the Med-QUEST staff members were friendly and supportive, even though they sometimes did not have answers to questions. (In contrast, we have typically found that welfare recipients feel that their caseworkers are rude or disrespectful to them.)

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[39]The group with chronic health problems was selected to include people with asthma, diabetes, or mental illness, as well as parents of children with developmental disabilities.

2. Selection of Providers

A common complaint in the focus groups was that people lost their previous doctors or dentists. In some cases, this was because their previous provider was not in the MCO they joined; in other cases, a person who had the right plan and requested that provider was assigned to someone else anyway. While many did not have strong provider preferences, others were upset that they lost their familiar doctor or dentist. Three respondents mentioned that they went to their out-of-plan providers at least once and paid out of pocket because they preferred their previous provider to their assigned doctor or dentist.

One extreme case was a woman who was admitted for surgery the day before her QUEST policy went into effect and found that she had a different set of doctors assigned on the day of surgery. Although she did not have complaints about the quality of care the doctors provided, she found this change disconcerting.

3. Other Medical Issues

A few people mentioned that they encountered difficulties getting the care they wanted because of perceived barriers in the system of gatekeepers and authorizations.[40] For example, one woman had difficulties getting her Norplant (a contraceptive implant) removed, although she was experiencing side effects. Another woman's primary care physician was unwilling to refer her for an X ray or to a specialist, so she paid $300 out of pocket for an X ray that proved to her primary care physician that she required specialized care. Others, however, reported that they were very satisfied with the care they received. One woman with chronic health problems was satisfied with her care, but was upset that now, for the first time, she had copayments for her medications. While she continued to get the drugs, she had to pay part of the cost.

[40]We were not able to verify the circumstances of any of the problems mentioned in the groups. It is possible that some reports were exaggerated or that extenuating circumstances sometimes were not mentioned.

Parents of children with developmental disabilities expressed grave concerns about the prospect of requiring managed care for the disabled, as QUEST Phase II would require. They were worried that the network of specialized providers would not be available or that the plans would try to limit services.

1. OTHER VIEWS

We also met with a few advocates and some key legislators in the state. Compared with other states, there has been relatively little advocacy involvement in QUEST. The main advocacy issues that we heard concerned tension between the QUEST MCOs and some of the state-funded public health services programs. (This is discussed further in Section G.)

The legislators we met were generally supportive of QUEST. They mentioned that, although the overall state budget required a 4 percent cut, QUEST and Medicaid were still popular and had been spared cuts. In contrast, many health programs operated by DoH were losing funds. They were aware of some complaints about QUEST, particularly from physicians, and hoped that the state would be cautious in deciding whether to implement Phase II of QUEST and how to do so.

J. DATA ISSUES

Some of the implementation problems mentioned previously were related to problems with data systems. Some delays and errors in enrollment probably were caused by problems in using HAWI and may be alleviated with the completion of a dedicated QUEST system. It was particularly problematic that the state and the MCOs did not agree about how many people were covered. The state hired a data processing contractor, Unisys, to develop improved data systems, including enrollment and encounter data for QUEST.

The state required that MCOs submit encounter data in lieu of claims data. Most of the MCOs reported that this was not much of a difficulty, since they were collecting claims-type data. Kaiser Permanente required greater efforts, since these are not part of their normal system. Initially, DoH was

responsible for collecting and processing encounter data, but this was later transferred to Unisys. Staff members at DHS and DoH have been helpful in providing access to QUEST encounter and SHIP claims data, although it is still to early to assess the quality or completeness of these data.

At least in principle, it could be feasible to collect prior Medicaid and GA data through the state's Medicaid Management Information System data system and get SHIP data for the people served by HMSA on a fee-for-service basis. There are, however, some questions about the quality of the SHIP data.

K. LESSONS LEARNED

Despite its limited experience with managed care, DHS was able to successfully contract with five medical, two dental, and one behavioral health MCOs and start operations within 1 year after HCFA approval, QUEST stimulated the managed care market in Hawaii in a broader fashion: one new medical MCO began, and one dental MCO came to the state to participate in QUEST. Most QUEST participants are served by newly developed networks; staff-model HMOs cover a small share of the caseload. Although the Kaiser Permanente HMO was a major presence in the state, managed care networks were unusual in the private market.

Implementation was not completely trouble free, however. Most important, QUEST participation exceeded projected levels, causing budgetary problems for the state. Higher-than-expected demand, shortages of experienced staff, and other problems led to months-long backlogs in application processing, delaying coverage and creating confusion. While managed care usually means that some patients must change doctors, the disorder of startup meant that some doctor-patient relationships were unnecessarily severed.

Many physicians are unhappy with QUEST, partly because it is viewed as a harbinger of broader managed care efforts. They feel that QUEST requires greater administrative efforts without more compensation. The extent to which physicians are capitated or partially capitated varies from plan to plan, but payment rates were typically based on prior Medicaid reimbursement rates. Hospitals were reserving

judgment until more experience had accumulated but had no serious complaints so far. FQHCs and public health providers felt threatened by the MCOs, but the state was trying to resolve some of the conflicts.

In three focus groups, program participants generally said that they were satisfied with the medical care they received, although they had some administrative complaints about QUEST or MCO operations (such as delays or confusion). People with chronic health problems were less satisfied with their medical care and with QUEST, however. Both clients and providers mentioned that the state did not provide much counseling to help select MCOs or to understand the rules of managed care. On the other hand, two signs show QUEST's popularity with consumers: (1) the higher-than-expected participation levels; and (2) the fact that, during the open enrollment period at the end of Year 1, less than 2 percent of the caseload elected to change MCOs.

Moving into the second year of operations, the state was modifying eligibility rules and premium levels to reduce participation. The state renegotiated capitation rates for the second year; in most cases, the second-year rates were lower than the first-year rates, in light of positive margins earned by MCOs in the first year. The major program changes made in April 1996 will be examined more closely in our next report.

For other states considering similar efforts, an important lesson is the need for adequate planning time: the 1- year horizon was barely sufficient, and more time could have helped. Some of the initial confusion and delays might have been reduced if implementation had been phased in more gradually. Additional communications with clients and providers might have eased many of these early problems. Another area that other states should carefully consider is how to pay for and provide care in the gap period between initial program application and eventual receipt of an MCO membership card.

V. TENNESSEE'S TENNCARE PROGRAM

Tennessee enrolled nearly 1 million Medicaid enrollees and uninsured people into its new managed care program, TennCare, on January 1, 1994. As has been previously documented (Coughlin and Lipson 1994; General Accounting Office 1995b; and Gold et al. 1995), this considerable achievement was accompanied by administrative problems, especially in the early implementation period. Eighteen months after implementation, the new governor continued the state's commitment to making TennCare work, and had taken steps to improve TennCare administration.

A. BACKGROUND

Tennessee sought a Section 1115 demonstration because of concerns about state finances in a climate in which Medicaid costs had been growing rapidly and new taxes were unlikely to be politically feasible. In addition, a large number of people in the state (about 675,000, or 15.7 percent, of the nonelderly population in 1990 to 1992) were without health insurance (Winterbottom et al. 1995). The timing of the application also had to do with the termination of a hospital tax at the end of 1993 (which had been the basis for disproportionate-share funding of the hospitals), the political opportunity presented by the President's support of state Section 1115 applications, the national health care reform debate, an experienced democratic governor (Governor McWherter, who was nearing the end of his second and last term), and an experienced commissioner of finance and administration.

Tennessee's health care delivery system in 1993 was primarily fee-for-service, characterized by low Health Maintenance Organization (HMO) penetration and more hospital beds than needed.' Moreover, in 1993, Tennessee's Medicaid payments to physicians were high relative to other states and to 1993

'Tennessee had 4.24 beds per 1,000 people in 1993, 28 percent above the national average and nearly double the rate in Hawaii (American Hospital Association 1994).

Medicare fee levels (ratio of 0.94 for primary care but 1.10 for all physician services).* Thus, physicians in Tennessee were presumably relatively more satisfied with Medicaid payments than physicians in other states, although participation levels were not very high. In this setting, the state had considerable leeway in setting capitation rates for managed care organizations (MCOs), which it might not have had in a market with a tighter supply of providers and more competitive pricing.

Managed care was not widespread in Tennessee. The HMO penetration rate was only 5.7 percent in 1993 (although Nashville and Memphis were as high as 8 and 9 percent, respectively) (Group Health Association of America 1994). Furthermore, only 30,000 Medicaid enrollees (about 3 percent of Medicaid enrollment) were in any form of managed care.[3] Thus, the enrollment of 1.2 million people into TennCare MCOs during 1994 made a large change in the health care delivery system in Tennessee. One-third of TennCare enrollees were in HMOs in 1994; thus, the state's HMO penetration rate increased to about 14 percent after TennCare implementation.

This chapter is based on interviews, focus groups, and document review for the first 18 months of TennCare. We made two weeklong visits to Tennessee in May and June 1995, during which we interviewed state and MCO staff and staff of interest groups and providers and conducted focus groups with physicians and consumers. We visited the headquarters of five MCOs: the two statewide ones (Blue Cross/Blue Shield and Access MedPlus) and three smaller ones (Vanderbilt Health Plans, TLC Family Care Health Plan, and Prudential of Memphis). We also met with the representatives of six hospitals and three Federally Qualified Health Centers (FQHCs) in Chattanooga, Nashville, and Memphis. Memphis was the site of a more detailed case study. Documents were provided by HCFA, the state, and the MCOs.

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[2]However, payments per enrollee (excluding disproportionate-share payments) were low relative to other states: Tennessee ranked sixth from lowest (Winterbottom et al. 1995).

[3]Tennessee Managed Care Network, Inc., an Independent Practitioner Association (IPA)-model nonprofit HMO, operated in 28 of Tennessee's 95 counties, centered on Memphis in the southwest.

B. PROGRAM DESIGN AND IMPLEMENTATION

The TennCare program was designed, approved, and implemented in a remarkably short period, with very little input from stakeholders. The governor announced the program to providers and the legislature in April 1993. In May, the necessary legislation was passed, and the waiver application was submitted to the Health Care Financing Administration (HCFA) on June 16. It was approved on November 18, and the program was implemented 6 weeks later, on January 1, 1994. Table V. 1 shows the key dates. Reactions to the program were enthusiastic when it was first announced, because it promised to provide a solution to widely publicized state budget problems and would cover uninsured people. Antagonism to the program developed later, especially from providers after the state ignored their proposals to eliminate some of the demonstration's managed care features. Since implementation, the management of the program has been modified, for example, to increase oversight of MCOs, and public hearings have been held, which prompted the state to make further program modifications such as revised graduate medical education funding.

1. The Design Process

The demonstration program was designed by three policymakers: (1) the governor, (2) the commissioner of finance and administration, and (3) the Medicaid bureau chief. In late 1992, preliminary discussions began among this group on the large number of uninsured persons in the state, the looming budget crisis, and possible resolution of both problems through Medicaid reform. During the early part of 1993, the state's imminent budget crisis was widely discussed, and the governor made dire fiscal predictions about Medicaid. Because the state had failed to introduce an income tax in the previous year, and because the existing provider tax that was used to generate disproportionate-share payments to hospitals was ending, there was much scrutiny of possible alternative sources of Medicaid funding. The state also needed to find sources that the federal government would match. All providers opposed the possibility of a new provider tax (which was under discussion). Consumer advocacy groups were

TABLE V. 1

TENNCARE IMPLEMENTATION SCHEDULE

Date	Activity
November 1992	Commissioner of Finance and Administration approached Legal Aid about the TennCare concept
April 8, 1993	Governor met with key people for discussions
April 8, 1993	Governor announced plan
April to November 1993	Meetings with HCFA
May 17, 1993	Legislation passed by the General Assembly
June 16, 1993	Demonstration application submitted
June-December 1993	Biweekly meetings with consumers and advocates
October 1, 1993	Ballots mailed to current participants in Medicaid
November 15, 1993	Ballots due for Medicaid enrollees to sign up with Managed Care Organization (MCOs)
November 18, 1993	Demonstration approved
November 29, 1993	State executed contracts with 12 MCOs
December 1, 1993	Enrollees given 45 days to change MCOs
January 1, 1994	Demonstration implemented; all Medicaid eligibles receiving services through MCOs. Uninsured eligible from January 1
October 1, 1994	Enrollment closed to uninsured people with incomes above 200 percent of the federal poverty level
November 1994	First opportunity for enrollees to change plans after initial enrollment
January 1, 1995	Enrollment closed for all uninsured
April to May 1995	Governor's Roundtable met
September 9, 1995	HCFA renewed the demonstration for its second year with revised terms and conditions
September 1995	State modified the terms of the MCO contracts for the period July 1, 1995 forward

SOURCE: Interviews with state and other officials and documents they provided.

"People becoming uninsured because they lost Medicaid eligibility may still be enrolled as uninsured.

concerned about the possibility that without the demonstration, the state would end its optional coverage of medically needy people. Thus, all parties viewed the TennCare concept (unveiled in early April 1993), as an attractive funding solution because it did not include an explicit provider tax, would cover uninsured people, and would not limit Medicaid coverage.

The initial widespread support for the demonstration came both from the main provider groups, including the Tennessee Medical Association and the Tennessee Hospital Association, from bipartisan backing in the legislature, and consumer advocacy groups. The governor met with provider groups at his residence before the TennCare announcement on April 8, 1993, and requested that they not oppose the legislation. He and the commissioner of finance and administration and the Medicaid bureau chief briefed legislators during the subsequent 2- to 3-week period. The legislation amended some existing statutes, thus allowing the governor to seek waivers to the state's Medicaid program. The bill was passed by the General Assembly without any dissenting votes on May 17, 1993.

Important features of the pre-implementation period in Tennessee were the lack of public hearings and the development of considerable controversy. Once the content of the demonstration application became public in June 1993, a strong anti-TennCare lobbying effort began. The Tennessee Medical Association sued the state (unsuccessfully) to try to stop it from implementing TennCare and had discussions with HCFA about demonstration implementation. There were opportunities for providers to talk to the governor and state officials about the TennCare design. In retrospect, both sides agree that little of the provider groups' input was accepted, because many of their proposals involved abandoning key features of TennCare in favor of other designs. This lack of action antagonized the provider groups. Some have argued that, if the state had negotiated the design with provider groups, it would never have been able to implement the new program because the groups would have tried to block design features (such as managed care) that made the program feasible. The resulting antagonism affected provider participation during the early implementation period

During the 6-month period leading up to implementation, consumer advocates met biweekly with the commissioner of finance and administration and the Medicaid bureau chief to talk through how TennCare would handle specific issues. Potential MCOs also reviewed draft versions of the state's MCO contract during this period. The comments of these two constituents were the only public input into the design that the state accepted.

During the period between application for and approval of the demonstration, the state met frequently with HCFA staff to finalize the design and to clarify the state's funding mechanisms for the program. Some of the details were not ironed out before approval, and the terms and conditions of the approved demonstration (dated November 18, 1993) required the state to provide a revised first-year budget and details of quality assurance and other state responsibilities.[4]

2. Key Design Features

We give a brief overview of the design here, with details of the TennCare program presented in later sections of this chapter. The major objectives of the TennCare program were to provide coverage to uninsured and uninsurable Tennesseans, to fund that coverage through savings in the Medicaid program, and to control Medicaid costs, To achieve these objectives, TennCare required enrollment of virtually the entire Medicaid population in managed care and offered TennCare coverage to uninsured and uninsurable populations, The expansion was not income-limited (as it was in Rhode Island and Hawaii), although people in the expansion group with family incomes above the federal poverty level had to share in the costs

[4]In addition to waiving various Medicaid statutes for the demonstration, HCFA specified special terms and conditions of the demonstration's implementation and operation. The 35 conditions specified for the first year included state monitoring responsibilities (for example, an annual sample survey of enrollees to assess satisfaction and collect encounter data), state reporting responsibilities to HCFA (for example, quarterly progress reports), and a description of how the federal match to state expenditures would be determined (for example, the calculation of the portion of enrollee premium payments that are matchable). Second-year terms and conditions modified a number of the first-year conditions and added five new conditions, one concerning the state's cooperation with HCFA's evaluation of TennCare and four requiring information on specific program operations (such as the grievance procedure and how individuals change plans).

of their coverage. The covered population had to enroll in one of 12 managed care organizations (the 2 largest of which--Blue Cross/Blue Shield and Access MedPlus--were statewide and enrolled three-quarters of the total TennCare enrollment). The MCOs contracted with the state to provide the service package (an expansion of the services covered under Medicaid) in exchange for a capitation payment (all MCOs received the same rates for specified categories of enrollees).[5] The MCOs were not required to use a primary care gatekeeper model initially, although some of them did so. A significant design feature was Blue Cross/Blue Shield's physician mainstreaming feature. Blue Cross required physicians participating in its Tennessee Physician Network to accept TennCare patients. Because this network was at the heart of the Blue Cross/Blue Shield state employees' PPO, physicians accepting state employees as patients also had to accept TennCare patients. This requirement was very unpopular among the network's physicians, partly because TennCare paid less than the state PPO.

TennCare is administered by the TennCare Bureau, which took over from the Medicaid Bureau, with many of the same staff members. The TennCare Bureau was part of the Department of Health during the first year of the program

3. Startup

TennCare was implemented statewide on January 1, 1994, with all Medicaid-covered enrollees converting to TennCare coverage through their MCO on that date. TennCare had its share of problems in the early months, as one would expect from such a large program change involving so many enrollees, providers, and MCOs.

In Tennessee, providers and plans criticized the overnight change to a full managed care program. Some of the plans told us that they had never expected HCFA to approve the demonstration, or that they had expected HCFA would require a longer implementation period after approval. They also believed that

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[5] Long term care services are carved out and are paid on a fee-for-service basis.

the only explanation for the rapid implementation schedule was political pressure, which had resulted in more problems than would otherwise have occurred.

4. Program Changes Since Implementation

No major program changes were made during the first year. One year after implementation, in early 1995, however, a new Republican governor took office. Among his first actions were to move responsibility for TennCare from the Department of Health to the Department of Finance and Administration (following the de facto reporting lines). He also created a new deputy commissioner post in the Department of Commerce and Insurance, with expanded responsibilities for approving and monitoring MCO contracts. He appointed a new commissioner of finance and administration and a new TennCare Bureau chief when the incumbents, who had developed TennCare, left their positions in early 1995.

The new governor also set up a policy advisory committee, headed by the commissioner of finance and administration, to advise him on TennCare. This committee was responsible for setting up the Governor's TennCare Roundtable--the first TennCare public hearings. In his election campaign, the new governor had promised to allow providers to provide input into TennCare through-a public hearing process.[6] The Roundtable was announced on February 23, 1995. It prepared recommendations (on the basis of testimony received from MCOs, providers and advocacy groups) and published them in a report on June 29, 1995 (Governor's TennCare Roundtable 1995). The eight recommendations were to (1) reexamine the financial assumptions of TennCare, (2) form an advisory operating committee to eliminate hassle, (3) restore graduate medical education funding, (4) create a standard formulary across MCOs and a formulary oversight committee, (5) move as soon as possible to a true managed care/gatekeeper system, (6) reduce the problem of adverse' selection, (7) improve MCO oversight and accountability, and (8)

[6]He had also promised to repeal the controversial provision under which Blue Cross/Blue Shield providers that accept state employees must also accept TennCare members; however, he did not do so.

develop a program of patient education on how to access TennCare services. These broad goals were supported by detailed recommendations, such as increasing capitation payments substantially.

During 1995, the state intended to expand TennCare to capitate two other state-funded programs: (1) the program for the severely and persistently mentally ill (SPMI), which provides mental health services to people who have chronic mental illness; and (2) the Children's Plan, which provides services to severely emotionally disturbed children. The SPMI program was headed for implementation in mid-1995, but HCFA required further evidence of the state's readiness for implementation. HCFA approved the program in April 1996. The Children's Plan is currently on hold.

C. PROGRAM FINANCING

1. The Budget

The 5-year TennCare budget proposed by Tennessee and accepted by HCFA is $19.6 billion; the federal share is $11.6 billion and the state share is $8 billion.' Of the total state costs, $5.7 billion were eligible for federal matching.* This budget included the costs of long term care services (which are not included in the demonstration), program administration, and Medicare payments for dually eligible enrollees. Tennessee estimated that, without the TennCare demonstration, an additional $3.2 billion in federal matching funds would have been required over the 5 years. Table V.2 shows this 5-year budget, together with the sources of state funding.

The state proposed a variety of funding sources, some of which were needed to replace the hospital tax of $404 million a year that the state had collected until January 1, 1994. Most of these sources of funds would be eligible for federal matching payments:

'This budget was dated November 10, 1993. It revised and replaced the budget included in the June demonstration application.

*Tennessee received a federal matching rate of 67 percent during the period covered by this report (that is, for every eligible dollar spent on the Medicaid program in Tennessee, the federal share is 67 cents and the state share is 33 cents).

TABLE V.2

TENNCARE SOURCES OF FUNDING, STATE FISCAL YEARS 1994 TO 1998

Sources of Funding (in Thousands of Dollars)	State Fiscal Year 1993-1994	State Fiscal Year 1994-1995	State Fiscal Year 1995-1996	State Fiscal Year 1996-1997	State Fiscal Year 1997-1998	Total 5 Years
State Funds						
Medicaid Matched Funds						
State Core	$383,049	$394,541	$406,377	$418,568	$431,125	$2,033,660
Other State Health Funds	77,970	159,971	164,091	168,301	172,602	742,935
Certified Public Expenditures	63,546	127,092	127,092	127,092	127,092	571,914
Patient Revenue	20,858	101,082	106,136	111,443	117,015	456,534
Nursing Home Tax	80,300	84,000	88,200	92,610	97,241	442,351
Local Government	25,000	52,500	55,125	57,881	60,775	25 1,660
Broad-Based Tax (Hospital Tax)	202,176	0	0	0	0	202,176
Additional State Funds Required	185,259	170,880	197,548	225,903	256,037	1,035,627
Total Matched State Funds	**1,038,158**	**1,090,066**	**1,144,569**	**1,201,798**	**1,261,887**	**5,736,478**
Nomnatched State Funds						
Provider Charity Contribution	246,163	437,782	475,904	5 17,584	562,461	2,239,894
Total State Funds (Matched and Nonmatched)	**1,284,320**	**1527,848**	**1,620,473**	**1,719,382**	**1,824,349**	**7,976,372**
Federal Matching Funds	2,107,775	2,213,164	2,323,822	2,440,013	2,562,014	11,646,372
Total TennCare Funds (State and Federal)	3,392,095	3,741,011	3,944,295	4,159,395	4,386,363	19,623,159
Nondemonstration Services[a]						
Long-term care, Medicare payments, and program administration	(938,696)	(985,631)	(1,033,246)	(1,084,992)	(1,139,325)	(5,181,890)
Net Funds Available for TennCare Demonstration Component	2,543,399	2,755,380	2,911,048	3,074,403	3,247,037	14,441,269

SOURCE: Taken from the budget in the final demonstration application package (dated November 10, 1993).

[a]These services are not included in the demonstration. Instead, they continue to be provided on a fee-for-service basis. Expenditures for these services, however, are included in the demonstration budget and the federal spending cap.

- The state general fund ($2 billion over 5 years)
- Other state health programs that the state would have had to pay for (such as maternal and child health services) if TennCare had not been implemented ($743 million)
- Certified public expenditures ($572 million). These expenditures are the net cost to public hospitals and selected private hospitals of providing services to TennCare participants and people eligible for TennCare that are not reimbursed by the MCOs or any other payment source except local government funds for indigent care (that is, they are uncompensated care costs).[9]
- Patient revenue ($456 million); this is the total amount of premium payments for those uninsured enrollees who are required to pay them
- A nursing home tax, which will operate over the life of the demonstration ($442 million)
- A local government contribution, which represents local government subsidies for indigent care ($252 million)
- Additional state funds required ($1 billion). The existing HMO tax (2 percent of payments received), a PPO tax of 1.75 percent (implemented in May 1994), and general state funds (as needed) were contemplated as additional sources of state funds.

The state budget also included a source of funding that the federal government was not expected to match: provider charitable contributions ($2.2 billion over 5 years, or about 28 percent of the state's share of TennCare funding). The state wanted to limit program expenditures by building into the TennCare budget part of the value of charity care delivered by the state's providers before TennCare began (the state saw this as an alternative to taxing providers). The state estimated that the statewide value of charity care

[9]The second-year terms and conditions of the waiver define certified public expenditures as "actual expenditures certified by public hospitals for TennCare enrollees and eligibles, only to the extent that the public hospital is able to document that it has an actual unreimbursed expenditure for providing TennCare services to a TennCare enrollee or eligible which exceeds the amount paid to that hospital by the MCO, the TennCare eligible, any supplemental pool or other source (except for local government indigent care funds) for the cost of providing such services to TennCare enrollee or eligible as established through the hospital's audited Medicare cost report." In addition, in Knox and Davidson counties certified public expenditures are "actual expenditures for unreimbursed TennCare services provided to TennCare enrollees and eligibles in private hospitals in Knox and Davidson counties, only up to the amount of Knox and Davidson counties' indigent care funds that the Counties actually transfer to the private hospitals in Knox and Davidson Counties for these otherwise unreimbursed TennCare expenditures." The state decides how to use the federal funds that match the allowable uncompensated hospital costs and is not required to return these funds to the hospitals that incurred the uncompensated care costs.

was about 11 percent of total provider charges. TennCare would reduce, but not completely eliminate, the number of uninsured people seeking charity care; the state estimated that, once TennCare began, charity care would decrease to 5 percent of all provider charges. Rather than the providers enjoying the windfall from this expected reduction in charity care costs, the state reduced the TennCare capitation payments to MCOs. Five percent of provider charges translated into 20 percent of the expected value of capitation payments; thus, the state reduced capitation payments to MCOs by 20 percent.

2. Budget-Neutrality Requirements

A condition of waiver approval is that the demonstration be budget neutral to the federal government over the 5-year demonstration period. For Tennessee, an expected federal budget was set at the start of the demonstration, and the state must stay within it. Tennessee's federal budget cap is set as an aggregate program spending cap of $12.165 billion. This includes items not included in TennCare: long term care services, Medicare payments, and program administration. The first year was to be budget neutral, with the state able to receive up to $2.108 billion in federal matching funds (this assumed an increase in federal spending of up to 15.5 percent over the previous year); in subsequent years, the federal matching payments were to be lower, falling from 8.3 percent in the second year to 5.1 percent in the last year.[10] Although specified as annual limits, these are really targets, since the state was given some flexibility about which year it might receive the federal matching payments in (through a cumulative cap that was a little higher than the sum of the annual limits) during the first 4 years

The demonstration budget predicted that, over 5 years, TennCare would save the state $1.6 billion and the federal government $3.2 billion. These estimates assume that, without the demonstration program, Medicaid costs would grow more than 17 percent per year over the 5-year period." With the

[10]Thus, the cap averages 8.4 percent over the 5 years of the demonstration.

"The assumptions underlying this no-reform cost projection were that caseload would grow 10 percent per year (based on actual annual growth of 12.8 percent from 1989 to 1993); and per-capita cost would grow 8.3 percent per year.

demonstration, by contrast, the state assumed only 5 percent cost growth each year after the first--or, at worst, 8.3 percent cost growth per year. The state assumed it could hold cost growth to 5 percent per year under TennCare because that was the expected growth rate for the state's economy, and it expected that the TennCare increases would keep pace. In addition, the state believed that the experiences of other states with cost control through managed care lent plausibility to a 5 percent cost growth per year.

3. First-Year Financial Experience

HCFA raised questions about the adequacy of the state's funding sources before it approved the demonstration. These concerns seem justified by the state's difficulty in raising funds from some sources during the first year of TennCare.[12] The state overestimated certified public expenditures in its 1993-l 994 budget (at $64 million, compared to actual certified public expenditures of $34 million) (General Accounting Office 1995b). It also failed to collect the enrollee premiums it had anticipated, largely because it did not bill enrollees during the first 6 months as a result of administrative problems ($2.4 million collected, compared with $20.8 million budgeted in state fiscal year 1993-1994). These funding shortfalls reduced the federal matching dollars that the state could draw down. The state misunderstood HCFA's position on local government subsidies to hospitals as a source of federal matching, which led to another loss in federal funds. HCFA decided that local government payments for hospital certified public expenditures were not eligible for federal matching, because they were already matched under the local government line item (this reduced state funds that could be federally matched by $21 million in state fiscal year 1993-l 994 and $42 million in subsequent years). Because of these lower federal payments related

[12]The state's fiscal year runs from July 1 through June 30. Thus, TennCare began in state fiscal year 1993-1994. This fiscal year is sometimes described as state fiscal year 1994.

to state funding shortfalls, as well as lower-than-budgeted enrollment, first-year expenses were only $2.84 billion, compared with the first-year state and federal budget of $3.39 billion.

As a consequence of these problems in the first year, the state began investigating strategies that, in future years, would secure the full amount of federal funds it could receive. One approach was to raise capitation payments to MCOs more than the contractually specified annual 5 percent. The state implemented this change (an extra 4.5 percent increase) in state fiscal year 1995- 1996. Another possibility was to reinstate graduate medical education payments to providers, a Governor's Roundtable recommendation that the state was considering in state fiscal year 1995-1996 (Tennessee Managed Care 1995a) and which it subsequently implemented. In addition to these approaches, the state has revamped its procedures for premium collection from uninsured enrollees. However, a revised budget for state fiscal year 1995-1996 showed reductions in the expected revenues from patients to $30 million in 1995-l 996, compared with $106 million originally budgeted.

D. ELIGIBILITY AND ENROLLMENT

Under its Section 1115 demonstration, Tennessee enrolled all of its approximately 800,000 Medicaid participants, including the aged, blind, and disabled populations and dually eligible Medicare/Medicaid enrollees, into TennCare.[13] It also expanded eligibility to cover more than 400,000 uninsured and uninsurable people. All of these TennCare groups are enrolled in MCOs that receive capitation payments to serve them.[14] This enormous program expansion and the overnight change to managed care in a state that had low managed care penetration were accompanied by severe procedural and system problems.

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[13]The only excluded groups of Medicaid participants are qualified Medicare beneficiaries, qualified disabled working individuals, and state low-income Medicare beneficiaries.

[14]Medicaid-covered long term care services, however, are excluded from the capitation payment, as are Section 1915 waiver services, Medicare premiums, and Medicare crossover services.

1. Eligibility Policy

a. Medicaid-Eligible Enrollees

Before TennCare, the state's Medicaid program was restrictive. The state reported that, in 1993, the Aid to Families with Dependent Children (AFDC) program used an income threshold of 43 percent of the federal poverty level to determine eligibility, and the Supplemental Security Income (SSI) program for the aged and disabled used a threshold of 75 percent of the federal poverty level. The threshold for the state's medically needy program was 25 percent of the federal poverty level. In addition, Medicaid covered pregnant women and infants with family incomes to 185 percent of the federal poverty level, children ages 1 to 5 with incomes to 133 percent of the federal poverty level, and children born after September 30, 1983, to 100 percent of the federal poverty level.[15]

For Medicaid-eligible groups, eligibility for TennCare starts on the day of application (based on a Department of Human Services or Social Security Administration date stamp indicating receipt), in contrast to retroactive coverage under Medicaid, which covered people for a 3-month period prior to the date of application if eligibility could be verified for that period.

To avoid problems of people coming on and off Medicaid eligibility, the TennCare Bureau enrolls AFDC-eligible families and individuals qualified as "medically needy-eligible" for a minimum one-year period in TennCare. AFDC-eligible and medically needy individuals are given 30 days to reapply for coverage as uninsured at the end of the year if they have not been reverified as eligible by the Department of Human Services. If they already have been reverified, the TennCare Bureau re-enrolls them for another 12 months.

[15]Since TennCare began, the income thresholds for these Medicaid-eligible groups have changed little from the pre-TennCare levels.

b. New Categories of Enrollees

The state received waivers of Medical Assistance eligibility required to allow it to cover uninsured people, beyond mandatory or optional groups of Medicaid eligibility. These program waivers effectively opened TennCare to able-bodied adults and two-parent working families and allowed the state to eliminate the Medicaid income thresholds for the uninsured and uninsurable groups. The uninsured category covers any person not eligible for other health insurance as of a qualifying date.[16] TennCare also includes an expansion group of medically uninsurable individuals that covers any person turned down for insurance coverage because of a past or present health condition." Eligibility for these two expansion groups begins on the day TennCare receives the application. The TennCare Bureau redetermines eligibility for the uninsured and uninsurable groups after 12 months. Each expansion group enrollee receives a letter from the TennCare Bureau and must respond within 30 days or lose eligibility.

TennCare requires families and individuals in the expansion group whose incomes exceed 100 percent of the federal poverty level to pay premiums (see Table V.3). As of April 1995, nearly 200,000 individuals (about 44 percent of the expansion group) fell into the premium-paying group. Premiums are adjusted for income and family size. [18] For those above 200 percent of poverty, premiums are also adjusted by whether participants elect the high-deductible or low-deductible payment plan.[19] For one-person families with incomes between 100 and 200 percent of poverty, monthly premiums in 1994 ranged from $2.74 to

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[16] Individuals have to declare their lack of eligibility as of the date they apply and as of a prior qualifying date. Initially, the qualifying date for uninsured enrollees in 1994 was March 1, 1993. The qualifying date was subsequently changed to July 1, 1994, for enrollment after 1994; however, no enrollment took place in 1995, except for new uninsurable applicants and people who became uninsured as a result of losing Medicaid eligibility.

"About 3,900 people enrolled in the state's previous program for the uninsurable--the Tennessee Comprehensive Health Insurance Pool--were eligible for TennCare. TennCare superseded this program.

[18] The payments were based on the state employees' PPO.

[19] The state terminated the high-deductible plan in February 1996.

TABLE V.3

SUMMARY OF PREMIUM PAYMENT POLICY

Income Level Relative to the Federal Poverty Level (FPL)	Premium Required for Uninsured and Uninsurable?	Number (and Percent) of the Uninsured and Uninsurable Group in the Income Category[b]
Under 100 percent of FPL	No	248,337 (55.6)
100-199 percent of FPL	20 percent of the capitation rate	164,319 (36.8)
200-399 percent of FPL	20-100 percent of the capitation rate on a sliding scale[a]	28,007 (6.3)
400 percent of FPL and above	100 percent of the capitation rate[a]	5,651 (1.3)

NOTE: Medicaid-eligible enrollees in TennCare do not pay premiums.

[a] A lower premium was offered if the member accepted a deductible of $1,000 per individual ($2,000 per family) instead of $250 per individual ($500 per family). However, the high-deductible plan was terminated as of February 1, 1996.

[b] These counts of uninsured and uninsurable TennCare participants are before any terminations for nonpayment of premiums (that is, before the state sent termination notices out on April 25, 1995).

$19.15. For individuals with incomes between 200 and 400 percent of poverty, monthly premiums in 1994 ranged from $54 to $137 for the low-deductible plan. At 400 percent of poverty, individuals bear the full actuarial cost of the insurance. As a share of income, premiums range between 0.4 and 1.7 percent for people between 100 and 200 percent of poverty, and they are a constant 4.6 percent for individuals between 200 and 400 percent of poverty. The state collects the premiums.

TennCare enrollees with incomes above 100 percent of poverty are also required to pay a deductible and copayments. Deductibles and copayments are adjusted by income, family size, and payment plan type (high or low deductible); copayments are capped each year. For individuals with incomes between 100 and 200 percent of poverty, the annual deductible is $250, and copayments are limited to $1,000 per year. For individuals with incomes over 200 percent of poverty, the deductible is $250 for the low-deductible plan and $1,000 for the high-deductible plan. Family deductibles are twice the individual deductibles. Copayments are 10 percent of costs, subject to a maximum limit. Total out-of-pocket copayment costs, minus deductibles, are limited to $1,000 and $4,000 per year, respectively, for the low- and high-deductible plans (for both individuals and families). MCOs collect deductibles and copayments.

2. TennCare Enrollment Procedures

All Medicaid enrollees were automatically enrolled in TennCare as of January 1, 1994. However, Medicaid enrollees could choose their MCO. In October 1993, before waiver approval, the state sent ballot forms to Medicaid enrollees with instructions to choose a TennCare MCO for all family members by November 1. Whether or not people chose an MCO, they were enrolled in one and rolled over into managed care as of January 1, 1994. HCFA required the state to reopen plan choice for 45 days (from December 1, 1993 to January 15, 1994) because of enrollee confusion about MCOs (8 of the 20 MCOs listed on the ballots never contracted with TennCare) and lack of information about which providers were participating in each MCO at the time of the initial ballot.

Uninsured and uninsurable people had to apply for TennCare by mail. Application forms were widely available (for example, at hospitals, doctors' offices, county offices, the TennCare Bureau, and Department of Human Services offices). People receiving food stamps were also mailed an application form. The one-page form asked whether they had *ever* been turned down for health insurance and whether they had turned down insurance offered to them since March 1, 1993. It also requested age, race, household composition, employment status, gross monthly income, and physical disability status. The form instructed the applicant to choose an MCO.

All rollover Medicaid enrollees and new applicants were given a choice of MCOs in their region and were asked to rank their choices on their ballot or application form. Altogether, 60 percent of initial enrollees made an election. The individual was usually given his or her first choice. The state auto-assigned enrollees to MCOs under the following circumstances: (1) the enrollee did not make an election, (2) none of the enrollee's first three choices was available (the MCO withdrew from contracting or had reached its enrollment cap), or (3) the family selected different MCOs for different members. The state assigned enrollees in a three-phase process: (1) the state reviewed the claims history and tried to identify the primary care provider, then matched that provider to an MCO; (2) about 30,000 people already enrolled in the Tennessee Managed Care Network who did not choose an MCO were assigned to Access MedPlus because this was the successor plan; and (3) the state assigned the remaining unassigned enrollees in the same proportions as the choices made by those who made a selection themselves.[20] Some attempt was made to ensure that all categories of enrollees were distributed evenly across all plans; thus, disabled

[20]This assignment technique had the effect of rewarding those MCOs that used the most aggressive marketing efforts. Other states made assignments for those enrollees who did not select an MCO on the basis of reasons such as ensuring adequate enrollment in particular MCOs, or choosing the MCO that had bid the lowest capitation rates.

enrollees were not concentrated in a few plans. Family members were assigned to one MCO, which meant that some family members had to change doctors.[21]

Since the demonstration began, new Medicaid-eligible enrollees have been enrolled in TennCare and given a chance to choose an MCO at the time they apply for Medicaid. However, until 1996, there was no mechanism for new SSI enrollees to choose an MCO; the state auto-assigned all new SSI enrollees. However, all new Medicaid enrollees have 45 days to choose a different MCO after the initial choice or assignment.

Since the initial enrollment, there have been two open enrollment periods during which enrollees can change MCOs, one in October 1994 and another in October 1995. Between 100,000 and 150,000 enrollees (approximately 10 percent) changed plans during the first open enrollment period and 95,655 (8 percent) during the second period. The net change of enrollees primarily favored the largest plan, Blue Cross/Blue Shield, (as discussed in Section F)

3. Enrollment Implementation Issues

The state set up a hot line to help TennCare enrollees and providers with questions and problems. In the first few days of the waiver program, the hot line was swamped with about 50,000 calls a day. The volume of calls was much higher than anticipated, and the state eventually recruited state employees from other agencies to help out with the hot line. In the early months, about 250 people staffed the TennCare hot line 12 hours a day, 7 days a week.

The state was able to enroll nearly 1 million people into managed care in an unprecedentedly short period. However, the supporting eligibility information system had new demands (primarily communicating with the MCOs) placed on it. During the first 12 months of TennCare, the eligibility procedures and the supporting information system were not working as smoothly as users would have

[21] SSI-eligible enrollees sometimes could not be linked with their families and hence could be in a different MCO.

liked. Even after 18 months, some of the problems remained.[22] Continuity problems include inadequate procedures for registering newborns as TennCare members, problems with presumptive eligibility for pregnant women, and poor addresses and duplicate records. These were problems under Medicaid, too, but the consequences under managed care are greater. For example, with duplicate records, the state makes two capitation payments for one person, and the person may receive multiple MCO enrollment cards, Ifnewborns and presumptively eligible pregnant women are not enrolled and assigned to an MCO, providers don't know which MCO to bill and may be reluctant to treat them. TennCare revised presumptive eligibility procedures for pregnant women and newborn enrollment procedures 18 months after TennCare began, to facilitate immediate access to care. Pregnant women now receive a notification form to give to their physician at the same time they apply for TennCare. Similarly, to facilitate newborn enrollment, TennCare stationed outreach workers at key public hospitals to ensure that newborns are enrolled and the state is informed of the enrollment.

Problems also arose in checking the eligibility of uninsured enrollees for the program. The TennCare Bureau contracted with the Farm Bureau (a large insurance company) to verify the insurance status and incomes of the expansion group and to reverify insurance status and incomes one year later to re-establish eligibility. The process of checking eligibility for the uninsured group has not gone smoothly. It took, on average, between 45 and 60 days from application receipt at TennCare until verification was complete.[23] The state comptroller's office studied eligibility in 1995, determining that about 10,000 people enrolled as uninsured were ineligible and that the eligibility of an additional 262,000 people was unverifiable from the information they provided.

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[22]From the MCOs' point of view, some eligibility file problems resulted in inexplicable turnover in their member population, although some of this turnover resulted from the HCFA-mandated 45-day MCO change period that enrollees are allowed.

[23]The Farm Bureau had to contact the applicant to get approval for release of information. This release will be built into a revised application form to avoid the 30 days individuals were given to respond.

Some enrollees reported that it took a while (sometimes several months after they applied) for them to receive cards from their MCOs indicating their enrollment in those MCOs. As discussed in Appendix F, this lag sometimes delayed care access. However, MCOs are responsible for service coverage during this period (when a person is eligible, but has not yet received a card).[24]

Finally, as discussed in Section C, the state had difficulty collecting premiums from expansion group enrollees with incomes above the federal poverty level. During 1995, however, the state revised its collection procedures and disenrolled 82,674 expansion group enrollees who had not paid their premiums and were not willing to work with the state on a payment plan.

4. Enrollment Trends

Since its initial demonstration application, the state revised its expected total number of TennCare enrollees downward, in association with reductions in its estimates of total TennCare funding. The initial demonstration application estimated 1,775,000 enrollees a year. In its revised (approved) demonstration application, the state estimated 1,300,000 in the first year and 1,500,000 in subsequent years (and a total 5-year budget of $17.4 billion). A more recent estimate (October 1995) showed further reductions: 1,273,000 enrollees in state fiscal year 1996 and 1,300,000 in subsequent years (and a total 5-year budget of $16.2 billion).

After 1 year, TennCare had 1.2 million enrollees, two-thirds of them Medicaid eligible and the rest uninsured and uninsurable (100,000 fewer than budgeted). During the first 6 months of 1995, the total number of enrollees fell in both the Medicaid-eligible and the uninsured and uninsurable categories. Table V.4 shows the enrollment trends for Medicaid-eligible and uninsured and uninsurable enrollees. The reason for the reduction in the number of uninsured is that the state was not enrolling new uninsured people

[24]In the first year, a special fund (the unallocated fund pool) was established. It covered payments to MCOs during the first 30 days of coverage for uninsured and uninsurable enrollees. In 1994, the state distributed $20 million from this pool to MCOs.

TABLE V.4

TRENDS IN THE NUMBER OF ENROLLEES IN TENNCARE

Date	Medicaid Eligible	Uninsured/ Uninsurable	Total
2/94	N.A.	N.A.	722,073
7/5/94	N.A.	N.A.	1,076,632
12/12/94	836,808	414,408	1,251,216
04/21/95	793,450	446,611	1,240,061
04/28/95	793,876	415,444	1,209,320
06/23/95	800,397	398,594	1,198,991

SOURCES: First row: Tennessee Managed Care, December 1995, Table 4-2. Next four rows: TennCare Bureau. Last row: General Accounting Office (1995b), which received the data from the TennCare Bureau,

N.A. = not available.

during this period and was disenrolling individuals who had not paid premiums. The drop in Medicaid-eligible enrollees may be due to two factors. One possible factor is that some Medicaid-eligible people are actually enrolled as uninsured or uninsurable. [25] However, the *total* TennCare enrollment in mid-1995 (1,198,991) is 3 percent lower than the state's original estimate for the Medicaid eligible only at that date (1,241,239), suggesting that there has been a real decline in the Medicaid-eligible population covered by TennCare. A more probable explanation of the decline in Medicaid-eligible enrollees is that the state's economy is improving. [26] Two state trends suggest that fewer people need assistance: (1) the number of food stamp recipients dropped by 4.8 percent from 1993 to 1994 and by 10 percent from 1994 to 1995 (USDA Food and Consumer Service 1996), and (2) the number of unemployed people dropped by 40 percent from January 1993 to January 1995 (although there was an increase in the next 6 months) (Department of Labor 1994a, 1994b, and 1995).

Because of the shortfall in state funds (discussed in Section C), the state curtailed enrollment in the uninsured group at the end of 1994.[27] The state originally proposed that the uninsured group could enroll before the demonstration began and then again at annual open enrollment periods. In fact, uninsured individuals enrolled through most of 1994. The state closed TennCare to people with incomes over 200 percent of poverty at the beginning of October; to people with incomes between 150 and 200 percent of poverty on December 12, 1994; and to people with incomes below 150 percent of poverty on

[25] If a Medicaid-eligible individual applies to TennCare at a Department of Human Services office and is determined to be Medicaid eligible, then the state assigns that person to the Medicaid-eligible group. However, if the same applicant only applies to TennCare as uninsured, the state has no way of knowing that the person is Medicaid eligible.

[26] Another explanation would be that we are comparing the "ever-eligible" count with the "currently eligible" count--this a possibility we cannot ignore.

[27] HCFA set the criteria for closing enrollment to the uninsured population; the state agreed to them in a letter to HCFA dated November 11, 1993.

December 3 1, 1994. The proportion of the program's enrollment who were uninsured or uninsurable in December 1994 and June 1995 is fairly constant at one-third (see Table V.4).

The state's ambitious expansion to the uninsured resulted in about 400,000 uninsured individuals being enrolled in TennCare during the first 18 months of the program. The latest state-funded survey of consumer satisfaction and insurance coverage reports that, in September 1995, there were only 303,785 uninsured people in the state, approximately 6 percent of the state's population (Fox and Lyons 1995). This figure compares with the 675,000 in 1990 to 1992 reported by Winterbottom et al. (1995). The state attributes the reduction in the number of uninsured to the enrollment of many uninsured people in the TennCare program. However, as we have shown, part of this decrease may also be due to the improved economic conditions in the state.

E. SERVICE COVERAGE

The TennCare benefits are more generous than those previously provided by the Medicaid program. Some new services are covered:

- Adult inpatient psychiatric services and physician psychiatric inpatient services (people ages *21* to 65)

The limits on some services were eliminated:*'

- Outpatient physician services (no limits; previously limited to 24 office visits per fiscal year)
- Inpatient physician services (no limits; previously limited to 20 per fiscal year)
- Outpatient visits (no limits; previously limited to 30 per fiscal year)
- Home health visits (no limits; previously limited to 60 services per year, except durable medical equipment and supplies)
- Prescriptions (no limits; previously restricted to seven prescriptions or refills per month)

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[28]Commerce Clearing House, *Medicare/Medicaid Guide,* Para. 15,652.

Table V.5 lists the covered services. Although all of these services are covered, the ways in which MCOs implement coverage can vary. For example, each MCO has its own drug formulary, and, although durable medical equipment is unlimited, the types of equipment that individual MCOs cover may not be what participants are used to. Some MCOs offer additional services. For example, Access MedPlus offers adult vision and dental care at reduced prices (these are covered only for children under basic Ten&are), and Prudential Community Care plans to offer an annual preventive dental visit for adults in 1996.

A key measure of the success of managed care is whether patients have access to and benefit from the preventive care and continuity of care that managed care and use of primary care gatekeepers can offer. We have not yet evaluated access to the services offered by the MCOs, although some providers and consumers pointed out problems of access to dental and other services (see Sections G and H). However, we saw some changes in the use of emergency rooms in hospitals. To encourage use of primary care gatekeepers instead of the emergency room for primary care, the state originally proposed to charge a $25 copayment for emergency room use for primary care. Because HCFA cannot approve copayments for categorically needy Medicaid enrollees, this aspect of the program was dropped. However, the MCOs also have a financial incentive to reduce unnecessary emergency room use, and some have chosen to pay hospitals for primary care provided in the emergency room at primary care rates or to deny it altogether (and some hospitals complained that they and the plans were in disagreement as to what constituted an emergency visit). One change in the service delivery system that seems to have been hastened by TennCare is the development by hospitals of primary care clinics located near the emergency room to which they can triage primary care patients. Patients report being sent to such clinics when they show up at the emergency room.

TABLE V.5

TENNCARE BENEFITS

Services	Limits
Inpatient Services	
Inpatient hospital services	No limits Preadmission and concurrent reviews required
Physician inpatient services	No limits
Psychiatric Services[a,b]	
Inpatient Psychiatric Facility Services (all ages)	No limits Preadmission and concurrent reviews required
Inpatient Substance Abuse Treatment Program	Lifetime limit: two treatment programs no longer than 28 days each plus two 5-day detox stays
Physician Psychiatric Inpatient Services	No limits
Outpatient Mental Health Services (including physician services)	45 visits (75 percent managed care rate for first 15; 50 percent managed care rate for next 15; 25 percent managed care rate for next 15) Lifetime maximum benefit: $100,000 per individual
Outpatient Substance Abuse Treatment Program	Two treatment programs Maximum per program: $3,000
Outpatient Services	
Outpatient Hospital Services	No limits
Outpatient Emergency Room Services[c]	No limits
Physician Outpatient Services	No limits
Lab and X-Ray Services	No limits
Hospice Care	No limits
Dental Services	Covered for EPSDT-eligible recipients up to age 21
Vision Services	Covered for EPSDT-eligible recipients up to age 21
Home Health Care	No limits
Pharmacy	No limits
Durable Medical Equipment	No limits
Medical Supplies	No limits
Emergency Ambulance Transportation	No limits
Nonemergency Ambulance Transportation	Covered for EPSDT-eligible recipients and for Medicaid-eligible recipients lacking accessible transportation
Other Clinic Services	No limits

TABLE V.5 *(continued)*

SOURCE: Demonstration Application.

[a]For TennCare enrollees who are chronically mentally ill and receiving services from the Department of Mental Health and Mental Retardation, these limits do not apply.

[b]In July 1996, the TennCare Partners behavioral health care plan was introduced.

[c]The state proposed a $25 fee for nonemergency use, then reduced it to $6. HCFA could not approve this fee for the categorically needy. The state eliminated this fee (it may never have been collected by hospitals anyway).

EPSDT = Early Periodic Screening, Diagnosis, and Treatment

F. MANAGED CARE PLANS AND CONTRACTING

This section first describes the characteristics of the MCOs in TennCare. Next it discusses them in the context of prior managed care. Then it discusses the contracting process, state monitoring, MCO enrollment characteristics, and plan financial solvency.

1. Summary of MCOs

The state contracted with 12 MCOs, of which two operated statewide in the first 18 months of TennCare. These two MCOs include almost three-quarters of TennCare enrollees. The two MCOs are Blue Cross/Blue Shield (50 percent of enrollees) and Access MedPlus (24 percent).? Blue Cross/Blue Shield is classified as a PPO and operates a discounted fee-for-service plan without primary care gatekeeping.[30] Access MedPlus is an Independent Practitioner Association (IPA) model HMO and was the only MCO to have Medicaid managed care experience before TennCare (it operated as Medicaid Plus). Of the remaining 10 TennCare MCOs, the three largest are PPOs (Health Net, OmniCare Health Plan, and Preferred Health Plan); they have 17 percent of the enrollment among them. Of the remaining seven plans, six are HMOs, and four are offered in only one region; these seven plans have 9 percent of the TennCare enrollment among them. Table V.6 lists the 12 MCOs and shows their type, tax status, enrollment, and how many of the state's 12 regions they are offered in.

2. Managed Care in Medicaid

TennCare introduced managed care into a state with little managed care and a Medicaid program that was primarily fee-for-service. Eleven HMOs operated in Tennessee before TennCare, only one of which covered Medicaid enrollees (Access MedPlus). Three of those HMOs opened TennCare plans: Access MedPlus, Prudential, and John Deere/National Heritage.

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[29]All enrollment figures are as of April 21, 1995.

[30]PPOs are not required to offer primary care gatekeeping until January 1, 1997.

TABLE V.6

SUMMARY OF MCOs IN TENNCARE

Plan	Type	Tax Status"	Number of Enrollees	Percent of Enrollment	Operating in How Many Regions?	Percent of Enrollees in Its Market Area
Blue Cross/Blue Shield of Tennessee	PPO	For-profit	614,613	49.6	12 (Statewide)	49.6
Access MedPlus	HMO	Non-profit	293,069	23.6	12 (Statewide)	23.6
Health Net	PPO	Non-profit	76,915	6.2	4	20.9
OmniCare Health Plan	PPO	Non-profit	70,918	5.7	2	18.8
Preferred Health Partnership	PPO	For-profit	63,033	5.1	5	13.4
TLC Family Care Health Plan*	HMO[b]	Non-profit	36,158	2.9	1 (Memphis)	14.1
Phoenix Health Care*	HMO	For-profit	36,173	2.9	10'	3.3
John Deere Health Care/Heritage National Health Plan	HMO	For-profit	17,801	1.4	5	3.8
Vanderbilt Health Plans' Community Care*	HMO[d]	For-profit	12,856	1.0	1 (Nashville)	10.5
udential Community Care	HMO	For-profit	8,155	0.7	1 (Memphis)	3.2
Total Health Plus*	HMO'	Non-profit	6,436	0.5	1 (Knoxville)	9.3
TennSource*	PPO	For-profit	3,934	0.3	1 (Knoxville)	5.7
Total	--	--	**1,240,061**	**100.0**	**12**	--

SOURCES: TennCare Bureau reports dated April 2 1, 1995. Second and third columns from MCO contacts, '".

*Newly formed to take part in TennCare.

"Tax status as of 12/31/95. Health Net and OmniCare have since changed to for-profit status.

[b]Based on the Regional Medical Center and the University of Tennessee medical group.

'Operating statewide as of July 1, 1995.

[d]Owned by Vanderbilt University Medical Center.

[e]Owned by the University of Tennessee, Knoxville, but purchased by Blue Cross/Blue Shield October 1, 1995.

Four of the seven participating HMOs were formed especially to take part in the demonstration. These new HMOs were TLC Family Care Health Plan, Vanderbilt Health Plans, and Total Health Plus, each of which was sponsored by a major teaching hospital (The Med, Vanderbilt, and the University of Tennessee, Knoxville), and Phoenix Health Care. Among the five PPOs that participate in TennCare, four (including Blue Cross/Blue Shield), had existing PPO plans (TennSource, a small plan local to Knoxville was new).

TennCare contracts with the 12 MCOs, each of which receives a capitation payment to cover all Medicaid covered services for members except for long term care services. The MCOs must all provide primary care gatekeepers by January 1, 1997, but at the start of the program some PPOs (notably Blue Cross/Blue Shield) did not do so.

3. The Contracting Process and Key Contractual Conditions

The state offered enrollees a choice of MCOs throughout the state. Early in the design phase, the state enlisted Blue Cross/Blue Shield to offer a statewide plan and held discussions with other plans to determine their interest in participating in TennCare. Instead of formally requesting a proposal, the state put out the word that it was interested in receiving proposals from MCOs to participate in TennCare. During a 3- to 4-month period after the demonstration application was filed, MCOs discussed contractual conditions with the state. After the state drafted the final version of the contract (one version for HMOs and one for PPOs), it was nonnegotiable. On November 29, 1993, the state executed contracts with 12 of the 20 MCOs that were considering TennCare participation. Some of the 20 potential MCOs dropped out because they considered the capitation payments set by the state to be too low, other MCOs did not want an 18-month contract, and the state declined to contract with some MCOs because of concerns about their financial stability.

Two types of MCOs contracted with the state, and each type signed a different contract. Seven HMOs (including staff, IPA, and network models) contracted with TennCare. Five PPOs contracted with

TennCare; these are plans that use a restricted network of providers who accept discounted fee-for-service payments. A key difference between HMOs and PPOs was that the latter were not required to have primary care gatekeepers for the first 3 years of the program. Furthermore, because the HMOs accepted full risk, their contracts did not limit their administrative costs or profits. Because PPOs shifted risks to providers, their contracts limited administrative fees to 10 percent of their TennCare revenues and required savings on PPO operations to be shared. The PPO can keep 5 percent of savings but must share 5 percent with the providers and 90 percent with the TennCare Bureau. The PPOs are liable for any excess of administrative costs. TennCare does not offer reinsurance to the MCOs, although some have chosen to purchase it themselves. All but two of the plans initially signed 18-month contracts; the two statewide plans (Blue Cross/Blue Shield and Access MedPlus) signed 5-year contracts.[31] Eighteen months after implementation, all 12 MCOs renewed their contracts (the two 5-year contracts were also renegotiated). Since then, Total Health Plus (a small plan that lost 20 percent of its enrollment during the open enrollment period at the end of 1994) was purchased by Blue Cross/Blue Shield, and Phoenix Health Care became a statewide plan on July 1, 1 995.[32]

The participation of FQHCs was encouraged, but not mandated, by the terms and conditions of the demonstration. The terms and conditions specified that the state must require MCOs to contract with FQHCs. However, MCOs that could demonstrate to HCFA that they had adequate capacity and range of services to treat vulnerable populations could be relieved of this requirement. The terms and conditions further stated that MCOs should pay FQHCs either a risk-adjusted capitation amount or on a cost-related basis (however, the Medicaid requirement that FQHCs and rural health clinics should be reimbursed using Medicare cost reimbursement rules was waived). The state encouraged MCOs to contract with FQHCs and required MCOs that did not contract with FQHCs to justify themselves to TennCare. Some MCOs

[31]Plans had to operate in one or more of 12 community health areas designated by the state.

[32]By 1997, there will be four statewide plans, and all MCOs will have converted to HMOs.

(for example, Prudential Community Care in Memphis) have not contracted with FQHCs. The MCO contracts do not specify payment methods for FQHCs. Some MCOs (for example, Blue Cross/Blue Shield) pay FQHCs a discounted fee-for-service.

The state set different capitation payments for different categories of enrollees, but it paid all MCOs using the same set of rates, which averaged $1,213 per member annually ($101.08 monthly) during the first 6 months of 1994. The rates were based on historical costs of services trended forward. There are different rates by age, sex (during childbearing years), and SSI disability status.[33,34] The state discounted these historical rates 15 percent for anticipated managed care savings, yielding an average rate of $136.75 per member, per month. The state further discounted the rates for charity care (an average of $27.96 per member, per month in early 1994) and local government contributions (an average of $2.35 a month in early 1994). Finally, because plans are responsible for collecting deductibles and copayments from enrollees, the state further discounted the rates to account for the expected coinsurance and deductibles for each plan's mix of enrollees. Table V.7 shows the resulting average monthly payment of $101.08 per member. Several MCOs have chosen not to pass the deductibles and copayments on to enrollees.[35] MCOs are allowed to transfer collection of copayments to providers.

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[33]These rates excluded the costs of long term care and disproportionate-share hospital payments, but they included the costs of capital payments and graduate medical education payments.

[34]Furthermore, according to the General Accounting Office, the annual rates were calculated using the total number of enrollees during the year as a denominator (General Accounting Office 1995b). This did not take into account the fact that some enrollees had only partial-year enrollment.

[35]MCOs that do not pass on the deductibles and copayments include Access MedPlus, TIC, and Prudential Community Care. The amount of the deductibles, and the fact that, on average, only 16 percent of their members have to pay deductibles and copayments, means that, for the smaller plans, it may not be worth setting up a mechanism to collect the payment. For Access MedPlus, however, the amount of income given up must be several million dollars annually.

TABLE V.7

THE DERIVATION OF CAPITATION PAYMENTS
DURING TENNCARE'S FIRST 6 MONTHS

Eligibility Category	Monthly Rate Based on Historical Costs[a] (in Dollars)	Adjustments (in Dollars)	Average Monthly Payment (in Dollars)
Age Under 1 Year	$145.25		
Age 1 to 13 Years	50.60		
Age 14 to 44 Years (Male)	92.80		
Age 14 to 44 Years (Female)	153.32		
Ages 45 to 64	151.12		
Ages 65 and Over	67.19		
Blind and Disabled	315.74		
Medicare Dual Eligibles	80.97		
Weighted Average, All Categories	136.75		
Average Local Government Deduction		$2.35	
Average Charity Deduction		27.96	
Average Coinsurance and Deductible Deduction		5.35	
Average Monthly Payment to MCOs			$101.08

SOURCE: Contract between the state and the MCOs.

NOTE: The rates increased 5 percent on July 1, 1994 and 5 percent on July 1, 1995. The state approved an additional 4.5 percent rate increase on July 1, 1995 for MCOs in compliance with their contracts.

"These rates are based on historical costs trended forward, but include a downward adjustment for the savings the state expected from managed care.

The state increased the capitation payments by 5 percent on July 1, 1994 and on July 1, 1995, as planned, to account for inflation. In addition, the state increased the rate 4.5 percent for MCOs that meet contractual requirements during state fiscal year 1995-l 996.

Capitation payments to MCOs are supplemented by a risk adjustment pool intended to account for adverse selection. The state budgeted two adverse selection pools, each including $20 million in the first year: (1) the "high-cost" pool, which was to compensate MCOs for enrollees who have expensive medical conditions (as determined by selected diagnosis codes); and (2) the "adverse selection" pool, designed to compensate plans for "high utilizers." These two pools were subsequently combined. The state reported to HCFA that it had disbursed $20 million for 1994 and $40 million for 1995 from this pool as of the quarter ending December 3 1, 1995. MCOs are not required to pass these payments on to providsrs.

TennCare also supplemented capitation payments through payments from the unallocated funds pool in the first year. The unallocated fund pool is what is left over in the TennCare budget after capitation payments are made. The state expected a positive balance in 1994 because full program enrollment would not be realized until well after the program was implemented. During the first year of the demonstration, payments from the pool went to both MCOs and providers. MCOs received $20 million to supplement the costs of services during the first 30 days of care for uninsured or uninsurable TennCare enrollees. This payment was intended to account for the possibility of a backlog of health care needs in this population.[36,37]

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[36]There were additional payments from the unallocated fund pool in 1994. Providers received most of the disbursements: medical education payments ($48.5 million); payments to essential providers (such as sole community hospitals, public hospitals, and community health centers) for rendering services to individuals eligible for TennCare but not enrolled (sometimes referred to as "Qualified Medical Bills") ($1 18 million); and payments for high-volume Medicaid and Medicare essential acute-care hospital providers ($50 million).

[37]In a letter to the state (dated June 21, 1995), HCFA approved additional payments from the unallocated pool fund. The conditions of the letter were incorporated in the terms and conditions for Year 2 of TennCare (dated September 22, 1995). HCFA agreed on a one-time basis to pay federal matching funds for 100 percent of uncompensated care costs for two hospitals: (1) the Regional Medical Center in Memphis, and (2) Metro General/Hubbard in Nashville. HCFA required that $12 million and $6 million, respectively, of the federal funds should remain with these two hospitals (to assure quality of care for beneficiaries) and to allocate the remaining federal funds to a one-time pool for payments to medical institutions for medical education.

In addition to criticisms that the capitation payment amount was too low, some MCOs have asserted that the enrollment numbers on which payments are based are inaccurate and constantly changing. For example, Vanderbilt Health Plans charges that 9.6 percent of enrollments change each month. Some of the changes add enrollees for prior months, meaning that the MCOs have to cover the costs of people they did not know were in their plan and whose costs they thus could not manage. However, the state observes that many backdated additions result in payments for people who have not used services during the period, which offsets the costs of those who did use care in the period.

4. State Monitoring of MCOs

a. Financial Oversight

Until January 1995, the state undertook only limited financial oversight of TennCare, particularly of PPOs.[38] The Department of Commerce and Industry had statutory responsibility but no oversight authority for licensed HMOs. HMOs were required to submit audited annual statements to the department on all business lines, including TennCare. The only financial auditing was to assess whether HMOs were meeting the state's risk reserve requirements. The department had no authority to regulate PPOs, except for their private insurance business. PPOs had only to report year-end financial results to the department within 9 months of the end of the calendar year; thus, the first financial reports from PPOs were not due until September 1995. The comptroller's office undertook MCO financial oversight for the TennCare Bureau; it conducts year-end MCO audits for financial solvency. The first of these was being conducted 18 months after TennCare implementation, and no MCOs were found insolvent.

[38]The comptroller's office performed limited reviews of MCOs in February and March 1994, with follow-up reviews in September to November 1994, as part of a contract with the Department of Finance and Administration. These were scheduled one- to two-day, on-site reviews, following a checklist of contractual functions such as timeliness of claims processing, quality assurance, adequacy of provider networks, and MCO collection of deductibles and copayments.

One of the new governor's campaign promises was to increase TennCare oversight, and his first executive order in January 1995 did that. The TennCare Bureau was transferred from the Department of Health to the Department of Finance and Administration, giving the commissioner authority over TennCare. The governor established and funded a new division within the Department of Commerce and Insurance (under a new deputy commissioner) with responsibility for overseeing MCO finances and viability. This new division conducts ongoing review (including on-site MCO reviews by certified public accountants several times a year) to assess compliance with contractual requirements; the comptroller's office will continue to conduct year-end audits. As of May 1995, the new deputy commissioner was assessing the need for additional requirements and penalties if MCOs did not meet requirements.

b. Quality-of-Care Oversight

The terms and conditions of the demonstration specified three state responsibilities related to quality of care: (1) implementing an annual consumer satisfaction survey, (2) ensuring adequate network capacity, and (3) developing internal and external audits to monitor MCO performance.[39] The state has conducted annual consumer satisfaction surveys in August 1994, September 1995 and September 1996. The 1994 survey showed that 57 percent of TennCare heads of households considered the quality of care they receive as excellent or good, whereas 71 percent of all Tennessee heads of households considered the quality of care they receive as excellent or good. In 1995, however, the proportion of TennCare heads of households that considered their care excellent or good had increased 9 percent over 1994, to 62 percent. For all Tennessee heads of households, this proportion had not changed and was still 71 percent.[40]

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[39]HCFA specified conditions of adequate access in an attachment to the terms and conditions. The terms and conditions also required the state to submit for federal approval a list of quality indicators and methods to be used in internal quality monitoring.

[40]The survey showed similar results for children: 71 percent of TennCare households in 1995 thought the care their children received was excellent or good (up 6 percent from 1994), whereas 79 percent of all Tennessee households thought their children's care was excellent or good (no change from 1994).

The TennCare medical director and his staff approved the networks (and the MCOs' continuous quality improvement plans) before the MCO contracts were signed, and the comptroller's office reviewed the networks during their initial limited on-site review. TennCare uses the GeoAccess™ software quarterly, to assess network adequacy, both on an ongoing basis and when an MCO makes changes in its network or expands into a new region. The principal network adequacy issues we encountered were the loss of one-third of the Tennessee Physician Network (Blue Cross/Blue Shield's physician network) during 1994 because of the plan's mainstreaming provision (although most of these physicians had returned 18 months later) and the continuing difficulties physicians have getting referrals to surgeons. (These issues are discussed further in Section G.)

The state contracted with an external quality review organization (EQRO) to review and improve the MCOs' internal quality assurance processes: the grievance procedure, the credentialing procedure, adequacy of medical records, and a quality improvement/quality management program. During this period, some plans were still developing their internal quality programs, and the EQRO was still making recommendations for improvements after 18 months. During 1994, the EQRO worked with the MCOs on two chart reviews: one on immunization and one on prenatal care. Immunization rates were lower than the TennCare medical director hoped for, and most pregnancies started before TennCare began; therefore, although the charts showed improved prenatal care, these results do not fully reflect TennCare performance.[41] A quarterly meeting of the MCOs with the TennCare Bureau was established at the MCOs' request to review the approaches to and results of the chart reviews.

[41] Clinicians reported anecdotal evidence that prenatal care was starting later under TennCare than under Medicaid because there is no longer presumptive eligibility (it appears that presumptive eligibility is not working as well under TennCare during the first 18 months as under Medicaid). As discussed in Section D, these procedures have since been revised.

c. Marketing Oversight

Another area of MCO performance the state is required to monitor is marketing. There was widespread adverse publicity about the illegal and inappropriate marketing practices followed by one MCO early on (for example, this MCO enrolled prisoners in a state jail who were not eligible for TennCare). The state published marketing guidelines in May 1994. These guidelines disallowed such marketing devices as offering credit cards (which were offered initially by some plans), but still allowed some practices that are not allowed in other states (such as door-to-door marketing and offers of life insurance).[42] Marketing varies a great deal by plan among those we visited, with strong outreach and marketing practices by the statewide Access MedPlus and almost no marketing by the small, Nashville-based Vanderbilt Health Plans. Affordable (now OmniCare) and Access MedPlus appear to have been more aggressive than others in marketing before TennCare began, to ensure the market share they needed for financial reasons.

d. MCO Problems

Many of the plans were not ready to handle claims payment and other essential functions on January 1, 1994. Blue Cross/Blue Shield was a major exception; they began planning for a January 1, 1994 startup by setting up a new division and, in August 1993, hiring and training 300 new or transferred employees and installing a telephone system for customer service. Furthermore, this MCO was not changing administrative structures, and it already had a statewide physician network and claims-processing systems. At the opposite extreme was Access MedPlus, whose structure and size changed dramatically. It had to develop a statewide provider network. It had planned for a maximum of 150,000 enrollees (although it did not request a cap of this number) and received double that number of enrollees. It did not make advance purchases of the telephone and management information systems it would need until it was sure that TennCare would go ahead. Because the state comptroller's early monitoring activities

[42]Several plans offer additional benefits to attract members, which appear to be fairly important to members, and some of those MCOs that did not initially are now planning to do so (TLC and Prudential).

singled out Access MedPlus as not performing its claims-processing functions adequately, the state contracted for an external audit of the MCO in September 1994; the results of this audit have not been published. The implication is that, although Access MedPlus was still not performing well, its performance was not bad enough to terminate it. According to provider reactions to participating in Access MedPlus, this plan was still performing poorly with respect to claims processing 18 months after TennCare began. The chief executive officer of this plan told us that he felt the plan was still some months away from performing at the level it did before TennCare began.

5. MCO Enrollment Characteristics

As discussed, two plans, Blue Cross/Blue Shield and Access MedPlus, dominate enrollment in TennCare. The third largest plan is Health Net (with 6 percent of enrollment); in the regions in which it operates, Health Net has 21 percent of enrollment. In fact, it has higher enrollment than Access MedPlus in three of the four regions in which it operates (these figures are for April 1995).

The characteristics of plan enrollees vary considerably. OmniCare has enrolled strikingly different categories of members than the other plans; it has markedly more males age 14 to 44 than any other plan (3 5 percent of its enrollment, compared with 14 percent across all plans) (see Table V. 8). In consequence, it has smaller percentages of children under age 14 than the other plans (22 percent, compared with 29.4 percent for all plans); fewer blind and disabled (5.8 percent, compared with 13.1 percent across all plans); and fewer dually eligible members (1.3 percent, compared with 12.1 percent across all plans). Because adult males are not normally eligible for Medicaid, it should not be surprising that 64 percent of OmniCare's enrollment is in the uninsured/uninsurable category, compared with 36 percent across all plans. The university-based MCOs--Vanderbilt Health Plans' Community Care, TLC Family Care Health Plan, and Total Health Plus--have exactly the opposite pattern of enrollment. For example, Vanderbilt Health Plans (with only 1 percent of total enrollment) has above-average enrollment of infants and children (35.5 percent) and blind and disabled (17.0 percent) and fewer 14- to 44-year-old males (9.4 percent).

TABLE V.8

ENROLLMENT BY PLAN, BY CATEGORY OF ELIGIBILITY
(April 21, 1995)

Plan	Percent Uninsured/ Uninsurable	Percent Medicaid Eligible	Percent								Total
			< 1 Year	1-13	Males 14-44	Females 14-44	45-64	65+	Dual Eligible	Blind and Disabled	
Blue Cross/Blue Shield of Tennessee	36.9	63.1	2.6	25.6	13.9	22.1	8.2	0.8	13.4	13.3	614,613
Access MedPlus	29.3	10.1	2.7	29.3	11.9	22.6	6.3	0.7	12.1	14.4	293,069
Health Net	31.3	68.7	3.4	29.9	12.1	21.9	6.5	0.8	13.9	11.4	76,915
OmniCare Health Plan	67.7	32 3	1.7	20.3	35.4	23.0	10.9	I.7	1.3	5.8	70,918
Preferred Health Partnership	40 8	59.2	2.3	24.6	14.4	22.1	8.9	0.8	12.8	14.1	63,033
TLC Family Care I Health Plan'	24 4	15.6	3.2	32.6	10.5	22 7	5.6	0.8	9.9	14.6	36,158
Phoenix Health Care	36 0	64.0	2.6	27.5	12.7	27.1	1.3	0.9	9.4	12.6	36,173
John Deere Health Care/I leritage National Health Plan	35 4	64.6	2.2	27.4	l-i.2	23.5	5.9	0.6	11.6	11.5	17,801
Vanderbilt Health Plans' Community Care[b]	22.6	11.4	2.7	32.8	9.4	23.3	3.9	0.7	10.2	17.0	12,856
Prudential Community Care	29.7	70.3	4.0	28.9	8.5	28.2	5.7	1.1	7.5	16.1	8,155
Total Health Plus'	26.9	73.1	2.7	27.5	11.8	21.0	5.5	0.6	13.4	17.5	6,436
TennSource	29.4	70.6	1.9	25.0	17.3	19.0	6.5	0.7	14.6	15.0	3,934
Total	36.0	64.0	2.6	26.8	14.4	22.5	7.6	0.8	12.1	13.1	1,240,061

SOURCE: TennCare Bureau report dated April 21, 1995.

'Based on the Regional Medical Center and the University of Tennessee medical group.

[b]Owned by Vanderbilt University Medical Center.

[c]Owned by the University of Tennessee, Knoxville, but purchased by Blue Cross/Blue Shield October 1, 1995.

Moreover, it has only 22.6 percent of its enrollment in the uninsured group. The other two university-based MCOs have patterns of enrollment similar to, but less extreme than, that of Vanderbilt Health Plans.

The first opportunity for enrollees to change plans after initial enrollment was in November 1994. Only two plans (Blue Cross and Health Net, the largest and the third largest) gained members overall. Statewide, Blue Cross gained at the expense of all the other plans (its enrollment increased by 10 percent). Access MedPlus lost 8 percent of its enrollment statewide, but it gained at Blue Cross' expense in Shelby County, where it has long been established as a Medicaid HMO. Health Net gained in the South Central area, and more or less retained its market in the three other regions in which it operates (averaging a two percent gain). John Deere had the most significant losses proportionally (although this is a very small plan). Total Health Plus, the second smallest plan, lost 20 percent of its enrollment; Blue Cross/Blue Shield bought it in 1995. The open enrollment period was passive in that people not wishing to change plans did not have to send in a ballot; only about 10 percent chose to change plans.

6. Managing Care

The extent of managed care practices in TennCare is variable across MCOs. In a sample of five MCOs that we visited (Blue Cross/Blue Shield, Access MedPlus, TLC Family Care Health Plan, Vanderbilt Health Plans' Community Care, and Prudential Community Care), all of which are HMOs (except Blue Cross), the practices range from utilization management only (Blue Cross) to primary care gatekeepers, plus primary care case management for selected patients. All plans use utilization management, which includes both retrospective review of the appropriateness and patterns of service and concurrent review of hospital stays. All the HMOs use primary care gatekeepers, that is, they assign members to a physician or midlevel practitioner who provides primary care. Enrollees can only receive specialty care if their primary care gatekeeper refers them. Two HMOs use additional case management for selected conditions: Access MedPlus case manages pregnant women, and Prudential case manages selected chronic-care patients. Case management encompasses a variety of approaches, such as telephone

calls to remind members of appointments and monitoring calls to check on their health status. As noted earlier, most TennCare enrollees are in PPOs that are not required to use primary care gatekeepers until January 1, 1997. Blue Cross/Blue Shield was piloting some primary care gatekeeper models during 1995 but was having difficulty persuading enrollees to volunteer.

Among the HMOs, which use primary care gatekeepers, the plan usually assigns patients to gatekeepers initially, with enrollees having the right to change immediately. This is the model followed by Access MedPlus, whose enrollees may subsequently change physicians once a year. Vanderbilt Health Plans allows multiple changes of primary care physician per year, as does TLC (unless they are "unreasonable?), and Prudential asks enrollees to select a physician at the health center they chose. TLC also assigns some patients who have complex problems (such as sickle-cell anemia or HIV infection) to specialists as primary care gatekeepers.

The state delegated patient education about managed care to the MCOs and undertook no outreach or education in the first 18 months of TennCare. The plans themselves have been variable in the amount of education they provide or outreach they undertake. Among the five plans we visited, Access MedPlus described the most extensive activities. For example, it trained 37 outreach workers in urban areas and sends them door-to-door to provide education (such as reminding people to use their primary care gatekeeper instead of the emergency room for primary care). Providers were very critical of the general lack of patient education in managed care.

7. Plan Financial Solvency

Eighteen months after TennCare began, all of the plans were still operating, and none of the plans had been determined nonviable by the comptroller's office (a few months later, the second smallest was bought by Blue Cross/Blue Shield). However, some of the plans reported to us that they lost money in the first year. Of the five plans we visited, Blue Cross, TLC, and Vanderbilt reported that they lost money; Access MedPlus and Prudential reported that they made a little money (they were both close to breaking even).

For the two plans that also have a commercial product (Blue Cross and Prudential), the allocation of administrative costs to the TennCare or commercial plan partially determined the loss or gain. However, Vanderbilt's costs exceeded its TennCare revenues by 20 percent, and TLC's costs exceeded revenues by 8 percent. Net income is also available for 1994 for two other HMOs (Total Health Plus and Phoenix Health Care); the former lost money, and the latter barely made money (Tennessee Managed Care 1995b). All the MCOs believe that it is too early to tell whether it will be possible to make money in the long run; however, they all stressed that their continued participation depended on TennCare raising the capitation payments more than the planned 5 percent per year.

G. PROVIDER RELATIONS AND PARTICIPATION

At implementation, many providers continued to see patients without knowing which MCOs the patients belonged to and without any assurance that they would be paid. Thus, they faced a major change in medical practice under difficult circumstances. This section is based on discussions with hospitals, physicians, FQHCs, provider associations, public health departments, and a focus group of physicians in Memphis.[43] Appendix E presents a summary of the physician focus group. Though most of the providers we met with accept TennCare in principle, their early experience leads them to be highly critical of it compared with Medicaid. Their interpretation is that TennCare was intended to incorporate a tax on providers (to replace the hospital provider tax that ended as TennCare began). This is a realistic view, given the charitable contribution explicitly incorporated in state financing of TennCare.

1. Provider Networks

The adequacy of the provider networks was a major issue at implementation and has been the focus of continuing state attention. However, after 18 months, TennCare still has most of the providers it started

[43]We met with representatives of 6 hospitals and 3 FQHCs, met with 3 rural and 10 urban physicians, and talked to representatives of two public health departments by telephone.

with, and the physician networks have increased over those available at startup. The network issues that concern MCOs, primary care physicians, and hospitals are (1) Blue Cross/Blue Shield's loss of one-third of the Tennessee Physician Network initially (because the physicians objected to the mainstreaming provision), (2) inaccurate network lists, and (3) continuing difficulties getting referrals to specialists.

The Blue Cross/Blue Shield problem was largely self-resolving. Most of the physicians had rejoined the network by the end of the first year, although many of our respondents questioned how many of the network physicians actually accept TennCare patients.

At the start of TennCare, when the MCOs' network lists first became available, it was clear that some lists were full of errors and others were inadequate to serve the number of members plans had enrolled. Since February 1994, the state has been reviewing the provider networks (as an element of state oversight of plans) and working with plans to improve them. When Health Net had too few physicians in its network in one region, the state allowed it to establish networks by county within the region, instead of for the region as a whole, and to enroll patients in the counties where it had adequate networks. However, the state's network adequacy evaluations look mostly at geographic distance of members from physicians, rather than at whether the providers in the network accept TennCare patients and how much excess capacity they have to accept additional patients.

We spoke with providers in Memphis and a nearby rural area whose main worry about TennCare was the difficulty of getting specialty referrals. The difficulty is most pronounced for access to surgeons, especially neurosurgeons and orthopedic surgeons, none of whom want to accept TennCare patients. Physicians spoke of prolonged periods on the telephone trying to persuade other physicians to see their patients. One Memphis hospital indicated that, in an attempt to put counter-pressure on the specialists who are not participating in TennCare, it was considering making it a condition of admitting patients to its hospital that physicians accept TennCare patients.

Perhaps because of the excess supply of hospital beds in Tennessee, most hospitals are participating in TennCare, and none of the hospitals we visited had dropped out of TennCare after 18 months, although some were limiting their dealings with inefficient plans. FQHCs and public health departments are participating in TennCare. The Memphis Public Health Department is a major participant in TennCare, with six primary care clinics, while the West Tennessee County Health Department's participation is limited to dental and Early Periodic Screening, Diagnosis, and Treatment services, These providers all participate in Access MedPlus, and some also take Blue Cross/Blue Shield and other MCOs' patients.

2. Adequacy of Payment Methods and Levels

The principal provider payment issues in TennCare are (1) low payments by Blue Cross/Blue Shield to all types of providers, (2) slow rates of payment by Access MedPlus to all types of providers except public health and community health center providers in Memphis (long-time members of this plan's network), and (3) high rates of denial of providers' claims. The specific method of payment and the level of payment, although important for particular providers with respect to specific MCOs, was in general less important to them than getting timely payment. Hospitals reported large increases in their days in net accounts receivable since TennCare began, because MCOs pay more slowly than the state did under Medicaid. Hospitals also deplored the loss of graduate medical education and disproportionate-share payments. The state has responded to the timely payment problem by placing more stringent requirements on the MCOs to make timely payment in the new contracts.

Payment methods vary widely both across MCOs and within MCOs for different types of providers. For example, Blue Cross/Blue Shield generally pays heavily discounted fee-for-service, even to FQHCs that received cost-based reimbursement under Medicaid; it pays hospitals on a diagnosis-related group basis. Access MedPlus pays hospitals on a per-diem basis and pays primary care providers through age- and gender-adjusted capitation rates (with an annual risk limit of $7,500 per patient); primary care physicians we spoke with considered these rates good.

All hospitals are having problems with high rates of denial of claims by the plans, which they consider a hidden cost of participating in TennCare.[44] A principal cause of denial by Blue Cross/Blue Shield is lack of timely filing. (Blue Cross requires clean claims to be filed within 90 days; providers have difficulty complying with this when enrollment information is inaccurate.)[45] Another problem is denial of emergency room service claims by many plans on the grounds that they were not emergencies (hospitals would then usually be paid at the primary care rate). This problem arises because MCOs base denial on diagnosis, whereas hospitals base service on the need to rule out more serious problems. Many hospitals have triage systems in place in the emergency room, some predating TennCare, and they expect the plans to accept the results of their triage process. Across the state, providers complained bitterly about high rates of denials (as well as slow payments) by Access MedPlus.[46] For example, one provider criticized Access MedPlus for inexplicable and multiple causes of denial that are too expensive to follow up individually.

3. Provider Actions

The state anticipated that there would be some changes in the market as a result of the major changes brought about by TennCare. If change is to occur, respondents suggested that long-term, planned provider closures are better for patients than overnight closures.

Le Bonheur Children's Hospital in Memphis provides an example of a provider with unusual market power adjusting to the changes brought about by TennCare. Before TennCare, the hospital was paid 91 percent of its costs for Medicaid services (when graduate medical education and disproportionate-share payments were included). Payments by TennCare MCOs have been slow, and the hospital reported that

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[44] One hospital in Memphis has required plans to post performance bonds before it accepts their patients.

[45] The state contract with Blue Cross/Blue Shield was revised after 18 months to require a clean claim filing period of 120 days.

[46] Access MedPlus has good relationships with its traditional providers in Memphis that it is able to pay rapidly.

payments cover only 67 percent of costs and that days in accounts receivable leapt from 67 before to 207 days after TennCare implementation. The hospital took action in April 1995 to collect the $11.5 million the MCOs owed it. The hospital, recognizing its market power as the sole children's hospital in the region, told the plans that unless they met the following requirements, their patients would be seen only on a full-charge basis. The plans were to pay the hospital a new rate that blended acute and chronic care; the plans were to pay periodic interim payments with timely reconciliation; the plans were to accept the hospital's emergency room protocols and not refuse to pay for services on the basis that they were not true emergencies; and, finally, the plans had to demonstrate fiscal soundness by posting performance bonds. The last requirement was because the hospital believed that its receivables were at risk, especially from Access MedPlus. The hospital believed that the plans did not understand their liabilities and thus were not operating soundly. The MCOs grudgingly accepted these terms.

The state government promised providers that they would not suffer under TennCare. The Regional Medical Center ("The Med") in Memphis, however, is an example of a safety net provider that may not be able to adjust to the changes brought about by TennCare. It continues to be in a financial crisis. The Med was heavily subsidized under Medicaid, through both disproportionate-share payments and its city subsidies; although it continues to receive the city subsidies for providing indigent care, it lost a major source of income when disproportionate-share payments ended with the start of TennCare. The Med is now much more dependent on direct service payments, and it believes that the payments it receives from MCOs are too low because it has adverse patient selection (although this will probably be somewhat reduced as a result of the recent closure of the coronary care unit). Like Le Bonheur, The Med is still trying to get paid by the MCOs for services provided. There are two aspects to this problem: (1) disagreements about TennCare enrollee eligibility between The Med and the plans, and (2) slow payments (an increase in net days in accounts receivable, from 63 in 1993 to 129 as of November 1994). The Med stopped taking nonemergency Access MedPlus patients in June 1995 as a result of slow payments by this

plan. In a settlement of first-year federal funding between the state and HCFA, The Med received a direct grant of $12 million to recognize the major adjustments it is making and to protect access of vulnerable Memphis populations to care. Thus, The Med's problems result both from high costs due to TennCare start-up problems and its patient mix. An advisory council set up by the mayor of Memphis reviewed The Med's finances and operations and concluded that The Med's problems are not caused by inefficiency (The Med Advisory Council 1995). Unless it changes its patient mix (which is antithetical to its mission) or receives increased payments, The Med will continue to lose money under TennCare.

4. Other Provider Issues

Hospitals, FQHCs, and physicians all complained about the increased 'administrative costs to them of TennCare, compared with Medicaid. These costs include the communication costs of checking eligibility, getting exceptions to the prescription formulary, and getting preadmission certification, activities that many providers stated had required them to increase their staff. Another increase has been in claims-processing costs; these costs have increased because many providers contract with more than one MCO (and MCOs have different procedures) and because they have had to process or adjust claims manually (because of Access MedPlus' inability to handle claims in this period). Physicians also complained about the lack of clinical training of the MCO staff members who handle clinical calls (such as calls concerning prescription drugs) and who thus waste their time. A widespread provider complaint was the high cost of MCO advertising, which they see as money diverted from clinical services. And finally, most providers complained about inadequate managed care education by the state and MCOs.[47]

H. CONSUMER VIEWS

This section is based on two focus groups of low-income consumers (one in Memphis and one in a nearby rural area) and one focus group of disabled consumers (in Memphis). Nineteen consumers

[47]The state reports that it is working on a clearinghouse in response to these concerns.

participated, not enough to generalize from but enough to suggest avenues for future evaluation. (See Appendix F for a full summary of the focus groups.) The level of consumer satisfaction with TennCare among focus group participants was fairly high, and the rural participants seemed more satisfied with the care provided by TennCare than the participants in Memphis. Disabled consumers, although generally satisfied, had particular concerns; some of them thought Medicaid was better than TennCare because it had allowed more physician and hospital choice. Despite their general satisfaction, the consumers identified problems with TennCare administration, physician choice, physician quality, prescription drug coverage, dental access, and access to primary care physicians.

1. Enrollment into TennCare

The consumers had heard about TennCare from a variety of sources, including health care providers, television advertisements, Department of Human Services caseworkers, an employer's insurance benefits coordinator, and a recruiter for one of the plans. Some of these sources were instrumental in enrolling the consumers in TennCare. Several of the urban consumers who had been in Medicaid before TennCare said that they had been switched over automatically with little problem, although some had found enrollment confusing. Comments on the caseworkers who handle eligibility were mixed. One Memphis consumer said a caseworker had not read the materials describing eligibility. The rural focus group participants, however, had all received help in enrolling from the Department of Human Services outreach worker at the hospital (this included two in the expansion group) and considered her extremely helpful.[48] The state had deliberately tried to keep the caseworkers neutral in the question of plan choice.

Many of the consumers did not choose their plan at startup, although 18 months later consumers understood much more about the enrollment process and the choices they could have made than they had

[48]These participants in the focus group were selected because they were known to the Department of Health Services outreach worker, however, so we cannot assume that everybody in the county had access to her.

at the time of startup. Some were not satisfied with the plan assignment and had changed plans, however. For example, one consumer said that she changed because no doctors took Blue Cross/Blue Shield. The local Department of Human Services outreach worker had advised the rural focus group participants to ask their physician about which plan to choose (there were only two choices for this group--Access MedPlus and Blue Cross). Several focus group members had changed plans at open enrollment in 1994, and others were considering changing plans in October 1995 (either to get a doctor who participated in that plan or to get extra benefits offered by some plans).

2. Primary Care Providers

Most of the consumers were fairly satisfied with their primary care physicians, although there were exceptions. One disabled consumer had to change physicians when he enrolled in TennCare because his previous physician (a specialist who saw him for all his needs) did not participate in TennCare. He frequently needed specialist attention for pain management but had to get a referral from his primary care physician for every specialist visit. In addition, this primary care physician was in an area he did not like to go to. Another consumer said that a doctor had given her the wrong treatment, and another explained that, after changing physicians, she was told to administer medications different1y.to her child. One consumer spoke of an uncaring physician who gave her prescriptions when she wanted a physical; she had complained about him to her plan. On the other hand, another consumer specifically said she did not feel discriminated against because she was a TennCare enrollee, and another praised the care her child received.

Some consumers had selected their primary care physician; others had been assigned a physician by their plan (either because they did not realize they had to choose one or because the plan had assigned an interim physician whom they could change during a limited follow-up period). The urban low-income focus group members least often chose their own doctor; only two out of seven had done so. By the time of the focus groups, the consumers understood that TennCare was about limited choice of physicians.

(They commented that the lists of doctors made it look like there is a choice, but it's more an appearance than a reality, because when you call they won't necessarily take you.) Some consumers still did not know how to change primary care physicians, however. For example, the mother of a child assigned to a general practitioner instead of a pediatrician wanted to change physicians but did not understand how to; the other focus group members offered her a lot of advice about how to change.

The participants felt that access to primary care physicians (appointments and travel times) was generally satisfactory. Most said that appointment waits ranged from 1 to 5 days, although a few complained of long waits for appointments (more than 2 weeks). One consumer with tonsillitis was told by her physician's office that she would have to wait several days for an appointment, so she went to the emergency room at Methodist Hospital. Methodist Hospital was able to get her an appointment with her physician for the next day. Two consumers complained about the location of the physician (one was a long travel time out into the suburbs from center city and another was the opposite). One-half of the disabled group was unaware that transportation to medical care was available. In the low-income group, however, there was a greater awareness of transportation availability: some said that their plan offered a taxi service, and others said that their clinic offered one. Several had used it. One pregnant women was using the taxi service to get to her regularly scheduled prenatal appointments. Most of the consumers, however, had a car or could get somebody to take them to an appointment.

Several consumers discussed problems they had getting prescription drugs and finding a dentist to accept them or their children. Some of the prescription drug problems were ones from early startup that had since been resolved. Others were more serious, such as having problems with the drugs on the formulary, which were different from what the patient was used to. One participant complained about the financial hardship of having to pay up front for her husband's TennCare prescription drugs and then get reimbursed by her plan.

3. Access to Specialists

The consumers understood that they had to have a referral slip from their primary care physician to see a specialist (unless they were in Blue Cross/Blue Shield), but they were not aware of the efforts the physicians undertook to get these referrals. Most consumers were satisfied with their access to specialty care (an exception was the disabled consumer mentioned earlier who had trouble accessing a specialist for pain management). The members of the disabled group in Memphis were anxious about what would happen to their access to specialty care if The Med closed. They were extremely happy with The Med and the specialists there, used The Med in emergencies regardless of which plan they were in, and were very critical of Access MedPlus (which they had heard had not been paying the hospitals and thus was causing financial problems at The Med).

I. OTHER VIEWS

1. Advocacy Organizations

Some consumer advocacy organizations have been actively supportive of TennCare, at least during the pre- and early implementation periods. They saw it as a program that could improve access to care and quality of care for the uninsured, while improving the benefits of Medicaid-eligible people. Consumer advocacy organizations reported that their comments to the state on TennCare were acted on during the pre-implementation phase. Over a 6-month period leading up to implementation, consumer advocates met biweekly with state officials to talk through how TennCare would handle specific issues. Not all advocacy organizations were involved in these discussions; some were limited to assisting their members to choose plans.

Eighteen months after the beginning of TennCare operations, the consumer advocacy organizations were identifying problems that they wanted the state to deal with. However, they were waiting to see how the new staff (especially the new TennCare Bureau chief) would handle the problems before applying pressure for their resolution. Areas that consumer advocates identified as needing improvement include

(I) access to care for the disabled population, (2) the grievance process, (3) the information flow from the state and MCOs to consumers (for example, with respect to whether a person is enrolled and with which MCO and premium notices), and (4) the fluctuations in MCO policies related to prescription drugs and durable medical equipment.

2. Legislators

Legislators did not fully understand the future impact of TennCare legislation. That is, they were relieved when the governor proposed TennCare as a solution to the well-publicized Medicaid budget crisis because it meant that the politically unpopular provider tax did not have to be renewed. Now that they have seen the results, some legislators are concerned that the state has passed too much responsibility to, and not retained enough financial oversight of the MCOs.

3. Provider Organizations

Once the implications of the governor's new program became clear, the Tennessee Medical Association opposed TennCare vigorously. The association represents about 6,700 physicians in Tennessee, excluding osteopathic physicians but including students. About 80 percent provide patient care, Initially, the association supported TennCare, but after it saw the demonstration application and understood the Blue Cross mainstreaming provision, it took legal action against the state to stop TennCare from being implemented. In an appeal of a ruling in favor of the state, the Tennessee Medical Association was told it should have sued the MCOs. Eighteen months into TennCare, the association accepts that TennCare is here to stay; it hoped that the new administration would make adjustments to TennCare to improve operations and put more money into the system so that physician payments would increase,

The state had planned to implement a behavioral-health program for the Severely and Persistently Mentally Ill (SPMI) just 18 months after startup. During the planning phase for a July 1995 implementation, the Tennessee Association of Mental Health Organizations (representing the community

mental health centers) opposed the SPMI startup because of concerns about the financing of the program and adequacy of the networks that the behavioral-health organizations (BHOs) were developing. Subsequently, HCFA retied to give the state permission to start the SPMI program in July 1995 because of the state's lack of readiness (the state had not approved the BHO's provider networks).

J. DATA ISSUES

Like the other states in this evaluation, Tennessee was initially having a lot of difficulty preparing encounter data that accurately reflected the services provided. It is not clear (and may never be known) to what extent all services provided to TennCare participants in the first year were actually billed, given the initial confusion. The problems the state faces include adapting its own processing programs from the fee-for-service model Medicaid Management Information System and holding the MCOs to collecting data of an adequate standard. The state can apply withholds to MCO capitation payments until it receives encounter data of an acceptable quality. It has also enhanced its leverage over plan production of encounter data by modifying the MCO contracts to keep withheld funds if the data problems are not solved after 6 months. It is clear, however, that some MCOs are having more difficulty than others and may need technical assistance to provide accurate encounter data.

The state has also had some problems with its eligibility files. These files have had to be adapted from Medicaid requirements to include additional information about category of insurance (to add the uninsured and uninsurable and identify those who must pay premiums and the family unit), as well as which MCO the client is enrolled in and the dates of enrollment. These files are critical to ensure accurate capitation payments to the MCOs each month. There has been a lot of criticism by the providers, MCOs, and consumer advocacy groups about discrepancies between the state enrollment records and the MCO enrollment records (which are generated from state records). Although duplicate enrollment records are less frequent under TennCare than under Medicaid, these duplicates can result in people apparently enrolled in multiple MCOs.

K. LESSONS LEARNED

TennCare had considerable adverse publicity when it began, though, as the program has matured, this has diminished. Nevertheless, while the scale of Tennessee's problems may have been unprecedented, similar problems have occurred in other states with Section 1115 waivers. Tennessee's problems were more severe in part because it implemented its demonstration program only 6 months after it submitted its demonstration application and implemented it all at once. In addition, Tennessee's is by far the largest of the recently implemented Section 1115 demonstration programs.

TennCare was approved and implemented in the shortest period of any of the three Section 1115 waiver programs this report discusses. HCFA approved the demonstration 5 months after Tennessee submitted an application for a Section 1115 demonstration to put its Medicaid population and an expansion group of uninsured people into managed care. The state implemented the program just 6 weeks after receiving waiver approval. This schedule was too short for adequate state and MCO planning, especially considering that the state had relatively little experience with managed care. Not surprisingly, despite hard work by state and MCO staff, the information systems needed for smooth (and sometimes basic) operations were not ready on the start date of January 1, 1994. Information was hard to come by, consumers were confused, providers delivered services without knowing whether or by whom they would get paid, and the state was not ready to oversee MCOs.

One of the MCOs (Access MedPlus), which enrolled about one-fourth of the TennCare population across the state, illustrates the problems that many of the MCOs experienced to a lesser degree at startup. Access MedPlus did not elect to cap its enrollment at the number it expected it could handle. Nor did it purchase important capital items until HCFA had approved the demonstration, because it could not bear the financial risk of purchasing new systems that it might not need. Thus, it had double the volume of enrollees it had planned for and could not process provider claims. With a longer planning period, there would have been greater operational readiness (although perhaps higher enrollment). However, all states

moving rapidly to managed care have had problems in the early years, so it is not clear that there would have been no problems in Tennessee with a longer planning period.

Tennessee's bold attempt to implement a major program in a brief period has become a cautionary but useful lesson to other states and also to HCFA. Other states considering demonstration applications have recognized the necessity of careful planning, phased-in enrollment, early system development, and MCO regulation and monitoring. HCFA has been far more cautious about allowing Tennessee to expand TennCare through capitating mental health services to the SPMI population. Approval for implementing that expansion was deferred until April 1996 while HCFA determined that the state was indeed ready to implement it.

TennCare was designed by a small team consisting of the governor, the commissioner of finance and administration, and the Medicaid bureau chief. They conceptualized, planned, and implemented the design with little outside input. While this approach enabled the state to implement TennCare during a narrow window of opportunity, it had two important weaknesses. First, the lack of attention to provider opinion resulted in increased antagonism from this sector. Second, the lack of knowledge about managed care led to weaknesses in design. Although the design team listened to providers' views, there were no public hearings, and the design did not incorporate many of the providers' ideas. Furthermore, the mainstreaming provision antagonized physicians and disrupted the physician networks in the early months of TennCare. Some have argued, plausibly, that the lack of negotiation with the providers and the mainstreaming were necessary to design and implement the program. Any discussion with provider groups would have prolonged implementation and made it politically less feasible, discussion might have derailed it altogether since providers would have demanded features incompatible with managed care or the state budget. Nevertheless, Governor McWherter's administration (which designed and implemented TennCare) made little effort after implementation to ameliorate provider antagonism by holding public hearings.

The lack of consultation with managed care experts during design (perhaps partly because of limited managed care experience in the state), together with the rapid implementation, resulted in continuing problems with information systems that were modified from fee-for-service uses, as well as lack of managed care education of consumers. These shortcomings also led to overoptimistic expectations concerning the likelihood that the MCOs would implement responsible managed care without considerable state oversight.

Perhaps the most important lesson was that the new governor elected one year after TennCare was implemented made no attempts to dismantle TennCare; on the contrary, he backed changes needed to make it work in the long run. One of the first moves the new governor made when he took office in January 1995 was to invite testimony and recommendations from the provider community for improving TennCare. The new governor has acted on some of the recommendations put forward during these hearings. Simultaneously, he made administrative changes to bolster state review of the TennCare program, to ensure that the MCOs were providing the service they were contracted to supply. Despite campaign promises, however, he did not remove the Blue Cross mainstreaming provision, which the medical community had hoped he would do. Thus, the demonstration is evolving in response to some of the early problems and the initiatives of the new administration, although it is too early to say whether the program will become financially sound and viable for the long term.

TennCare required providers to adapt and change medical and administrative practices, as the system changed from a largely fee-for-service Medicaid program to managed care. The change came abruptly to a state with little managed care experience, and had cost impacts on some providers. Some of the cost increases to providers were due to MCO start-up problems that were not all resolved after 18 months (for example, initial problems with MCOs' payment systems), and some of the cost increases were probably permanent (for example, the administrative costs of communicating with multiple plans), Moreover, providers were paid differently, and often less, under TennCare (although primary care practitioners may

have benefited most from payment changes). An important measure of the cash flow impact of TennCare is that a small sample of hospitals reported a doubling of the days in net accounts receivable under TennCare, compared with Medicaid. A systematic approach to making transitional payments to ease the necessary provider changes might have made for a smoother transition but would not have eliminated the need for providers to make changes in their practices.

The state expected that the introduction of TennCare would result in changes in the health care market, anticipating that some providers would close (after all, TennCare put nearly one fourth of the state's population into managed care). It planned only a one-year transitional period for extra provider payments, however, and these payments were conditional on low TennCare enrollment in the first year. Since TennCare began, the major changes in the way providers are paid under TennCare and the reduced amounts some of them receive for serving the TennCare population have led to concerns about the viability of some safety net providers. For example, the Regional Medical Center in Memphis (The Med) has lower revenue relative to before TennCare began and received a special payment of $12 million in 1995 to assure continued access for vulnerable populations. Some providers were unable to change the way they provide services as fast as the revenue streams have changed.

It takes time for organizations participating in a new program to understand how it works and how to act on this information to adjust to the program and survive financially. Providers at first adopted a wait-and-see attitude, but within 15 months of implementation, some had begun to act on problems (such as not getting paid by the MCOs). For example, Le Bonheur Children's Hospital in Memphis gave ultimatums to all MCOs it contracted with: they must pay what they owed and accept Le Bonheur's conditions of continued participation in the MCO. In the short run, this exploitation of market power was remarkably effective; the hospital received a large proportion of what it was owed. Other hospitals were beginning to consider whether they might use their market power to encourage specialists to participate in TennCare,

given the severe problems generalist physicians were facing in getting referrals for services (many of which would result in hospital admissions).

There has been inadequate managed care education by either the state or the MCOs. This applies both to the initial implementation and to ongoing operations. Although TennCare enrollees knew about the new program from brochures received in the mail, television and billboard advertisements, and door-to-door marketing, they did not necessarily understand their responsibility to choose a plan. In consequence, many Medicaid participants did not make plan choices. Because of the volume of incoming calls, consumers who wanted more information could not get through to the hot line the state set up to handle TennCare beneficiary inquiries. Because the state enrolled all Medicaid participants at once, the caseworkers could not be a major source of information (and were not intended to provide MCO recommendations); indeed, they appeared to have little more knowledge than what was in the plan brochures. The state did not do a good job of providing information to enrollees and has not provided ongoing education; it has left this to the MCOs. Some of the confusion could have been avoided if the state had planned for the high volume of calls it received or phased implementation in over a longer period. In recognition of the need for more managed care education, the state is now requiring the plans to send newsletters to members that will describe how managed care works and what their responsibilities are. It has also started an outreach program with the Department of Health.

An important lesson from TennCare is that there will be implementation problems and that the state and MCOs must be prepared to prioritize and handle them. In Tennessee's case, with the new administration, there seemed to be a growing recognition that the state also has responsibilities and that it cannot simply turn the demonstration program over to the MCOs. It must have adequate leverage in its contracts and must then monitor, exhort, and hold the MCOs and other contractors to the terms of their contracts.

There was an enormous demand for moderately priced health insurance from the uninsured population of Tennessee. During the first year of TennCare, 414,400 people enrolled as uninsured or uninsurable. However, it is not clear whether this expansion to cover uninsured people has a long-term future. The state has two problems: (1) a shortfall of funds needed to pay for the uninsured, and (2) uncertainty about the eligibility of those who are enrolled. Because the state has a complex funding mechanism for TennCare, and because it was not able to realize all the funds it budgeted for the first year, it stopped enrolling uninsured people after one year. Improvements in collections of premiums from the uninsured will presumably help keep this group an active part of TennCare. Plans for improving eligibility checking will also ensure that only eligible people are covered (although many of those who are ineligible may still not be able to afford health insurance).

VI. COMPARISONS ACROSS STATES

A. BACKGROUND FOR REFORM

These three Section 1115 demonstrations had both common and unique reasons for beginning. The projects have become more important as the health policy debate shifts from national to state issues.

The initiatives in Hawaii, Rhode Island, and Tennessee marked the beginning of a new wave of state health reforms. The states' Section 1115 demonstration applications, submitted and approved in 1993, were conceived at a time when national health care reform and universal health coverage were under active discussion. These three initiatives were spurred by a pledge given to the National Governors' Association by President Clinton, an ex-governor himself, to expedite approval of Medicaid waivers and increase state flexibility. In contrast, Oregon's Medicaid demonstration application, also approved in 1993, originated years earlier and was primarily motivated by factors inside the state.

The Hawaii, Rhode Island, and Tennessee initiatives were originally viewed as transitional steps in health reform that could eventually mesh with national policies. The collapse of national health reform proposals in 1994 increased the importance and visibility of these state projects as possible models for other state health reform efforts. In light of 1995 proposals to increase state flexibility in Medicaid and reduce Medicaid expenditure increases, these waiver programs may foreshadow how states would behave if given more autonomy.

An underlying cause of the initiatives in each state was the rapid escalation of Medicaid costs and resulting state budget problems, although most states in the nation faced similar problems (Coughlin et al. 1994). In addition to this shared concern, each state had its own motivations.

Hawaii wanted to further its role as a leader in health reform, being the only state that required employers to provide health insurance. The state sought to consolidate its state-funded State Health Insurance Program (SHIP) and General Assistance (GA) medical insurance with Medicaid and share the

costs of expanded coverage with the federal government. Its QUEST program sought to create a "seamless web" of health coverage.

Rhode Island was worried about problems with access to primary care (especially for mothers and children), and excessive use of emergency rooms by Medicaid recipients. RIte Care focused on expanding care for children and pregnant women. The main emphasis was on upgrading access to primary care services, instead of on containing costs.

Tennessee faced two key problems. First, when the state legislature let its Medicaid-related hospital tax lapse, funding for the Medicaid program collapsed and a fiscal crisis ensued. Second, state leaders were concerned about the high rate of uninsurance and wanted to increase health insurance coverage. The TennCare initiative sought to solve both problems at once and was quickly embraced by the executive and legislative branches of government.

B. PROGRAM DESIGN AND IMPLEMENTATION

The speed of program design and implementation often led to subsequent problems.

1. Program Design and Federal Approval

The three states moved quickly to design reform initiatives: all submitted applications in the first several months of the Clinton Administration. The basic structure of the reforms (see Table VI. 1) was generally determined early. During planning and after submission of the applications, the states engaged in multilevel discussions with federal officials. High-level state officials, including governors, met and negotiated with officials at HCFA, the Department of Health and Human Services, and the Office of Management and Budget. HCFA and the other federal agencies developed new approaches to review applications and negotiate terms with states in a timely fashion (Rotwein et al. 1995). Federal review was placed on a fast track, and each application was approved within 5 months of submission. State proposals were often modified or refined in light of federal officials' concerns. Two issues that were important in discussions were budget neutrality and quality, focusing on adequacy of provider networks.

TABLE VI. 1

KEY DATES AND MAJOR PROGRAM FEATURES

Characteristic	Hawaii	Rhode Island	Tennessee
Program Name	QUEST	RIte Care	TennCare
Date Waiver Application Submitted	April 19, 1993	July 20, 1993	June 16, 1993
Date Waiver Application Approved	July 16, 1993	November 4, 1993	November 18, 1993
Date Program Implemented	August 1, 1994	August 1, 1994	January 1, 1994
Main Eligibility Expansions	Coverage for nondisabled, nonelderly people up to 300 percent of poverty, if not covered by state employer mandate	Coverage expanded to pregnant women and children under 6 years old, up to 250 percent of poverty Family-planning services extended 2 n years after delivery u b	Insurance subsidized for uninsured and uninsurable people up to 400 percent of poverty. Uninsured people above this income level may join with s i d y .
Groups Shifted to Managed Care	Aid to Families with Dependent Children (AFDC)-type, General Assistance (GA), and State I lealth Insurance Plan (SHIP)	AFDC-type (includes poverty-related pregnant women and children)	All except certain Medicare beneficiaries.
Groups Not Affected	Elderly and disabled	Elderly and disabled	Certain Medicare beneficiaries: Qualified Medicare beneficiaries State low-income Medicare beneficiaries Qualified disabled working individuals
Services Not Affected	Long-term care	Long-term care; dental care and certain mental-health and substance abuse services	Long-term care; certain mental-health services
Program Size After 1 Year	157,000	70,000	1,25 1,000

Federal approval included terms and conditions that specified federal guidelines, including means of monitoring programs' budgets and management. Although our report focuses on the states, it is important to acknowledge that HCFA (at national and regional office levels) is a partner in these reform efforts, working with and monitoring states. Our impression is that HCFA has been more cautious in approving new waivers.

The rapid pace of design and development meant the states could expand insurance programs quickly. However, speed also had some political costs. In each state, at least one organization felt threatened by the changes and believed that state officials had not discussed the issues with them sufficiently. In Tennessee, this culminated in a lawsuit (eventually dismissed) by the Tennessee Medical Association to terminate TennCare. In Hawaii, physician associations encouraged the state senate to stop implementation, although the blockage was soon removed. In Rhode Island, the legal aid society and the community health centers considered lawsuits. At the national level, the National Association of Community Health Centers perceived a broader threat to Federally Qualified Health Centers (FQHCs) and filed a national-level lawsuit to suspend the demonstrations.

The composition and size of the demonstration populations varied widely across the three states, as discussed in more detail below. Tennessee's program was the most inclusive and the largest (1.2 million enrollees), while Rhode Island's was the most narrowly defined and smallest (70,000 enrollees).

2. Program Implementation

a. Schedule

The rapid tempo of implementation created major management challenges. Although problems occurred in each state, the implementation of major program changes in tight time frames was an impressive achievement of state and local officials, the managed care organizations (MCOs), and other staff.

Tennessee had the most ambitious schedule, implementing its program within six weeks of federal approval. It was spurred to move quickly because of its fiscal crisis; in fact, implementation began before federal approval was secured. For example, the state sent MCO enrollment ballots to Medicaid enrollees before federal approval was given and before the MCOs had signed contracts. Tennessee encountered many implementation problems (discussed in Chapter V), and most observers would agree that the extraordinarily short time span for planning and implementation (and the large size of the program) led to serious difficulties and controversy.

Both Hawaii and Rhode Island delayed their originally planned implementation dates slightly but still managed to imniement their programs within a year of getting their demonstrations approved. Rhode Island officially began its program in August 1994 but spread out the transition to managed care by gradually enrolling clients in managed care over a year-long period. By contrast, both Hawaii and Tennessee had massive transitions to managed care that occurred statewide for everyone on the day of implementation. The sudden implementation in these two states, combined with substantial eligibility expansions, created great confusion around the dates of implementation. Although Rhode Island also experienced some of the same problems, they appeared to be less acute because of the rolling implementation process

b. Management Issues

The demonstration programs required procedural and structural changes in the state agencies. With the shift to managed care, state Medicaid agencies changed their roles: they moved away from direct provider relations and reimbursement and toward oversight of MCOs, which are responsible for providing medical care directly or by contract with health care providers. All three states had limited experience with Medicaid managed care prior to implementing the demonstrations. Both Hawaii and Rhode Island used private consultants extensively to add expertise or resources not available among state staff

Each state undertook critical implementation steps: (1) developing MCO contracting procedures, including bidding or capitation rate setting; (2) starting or augmenting MCO monitoring and quality assurance systems; (3) developing procedures to enroll newly eligible people and to enroll all clients into MCOs; (4) upgrading communications capabilities (including telephone hot lines); and (5) building new data systems. Each state retained major portions of the fee-for-service Medicaid system for long-term care, and Rhode Island and Hawaii retained fee-for-service Medicaid for their aged and disabled populations. In the short term, states required *more* administrative capacity to implement the programs.

Structural management changes were common. In Rhode Island, RIte Care was managed by a newly formed Office of Managed Care, a joint effort of the human service and health departments. However, the office eventually was placed in the Department of Human Services, which administers Medicaid. In Hawaii, responsibilities held by the Department of Health for the SHIP program were transferred to the Department of Human Services. Control of the enrollment process shifted from the welfare offices to the Med-QUEST division. Much of the responsibility for TennCare policy shifted from the Department of Health to the Department of Finance and Administration. This *de facto* shift was later made permanent and official.

The availability and quality of encounter data are critical to our long-term evaluation goals and to states' ability to monitor the levels and quality of care MCOs provided. Each state has instituted processes to collect encounter data from MCOs and to edit and process the data, but progress has been slow. Each state had to work with the MCOs and systems contractors to define data systems requirements in compatible formats. The quality and completeness of these data will be reviewed but remain an open issue at this time.

3. Program Refinement Since Implementation

Major program changes always seem to lead to upheaval, controversy, and confusion at first. Since starting, each program has evolved and matured. While major elements of the programs have been

retained as the programs matured, state agencies, MCOs, and other groups have made many refinements. Our impression is that state agencies and MCOs have listened to complaints, discussed alternative solutions, and tried to make improvements. Programs are not static, and the upheavals common at the beginning do not necessarily reflect the long-term organization of the programs. The experiences of Arizona (the longest-running Medicaid Section 1115 demonstration project) indicate that, despite initial problems, challenges can be overcome with time and attention (see, for example, General Accounting **Office 1995c).**

C. FINANCING

The size of the eligibility expansions varies across the states, requiring different financing arrangements. To attain budget neutrality, Tennessee and Hawaii must generate substantial Medicaid savings and bring in new revenues to pay for the expansions. Rhode Island's more limited expansion carries little financial risk for the state.

1. Financing Arrangements

To approve a Section 1115 demonstration project, the federal government must determine that the demonstration is budget neutral, meaning that the federal expenditures will not be higher than they would be without the demonstration. An important change made in 1993 was that budget neutrality is measured over the project's 5-year lifetime, instead of requiring neutrality in each year. Thus, a demonstration project could cost more than the baseline in the first year (because of start-up costs), as long as neutrality or savings was attained by the fifth year. At both federal and state levels, budget neutrality assumptions were paramount considerations. Tennessee and Hawaii envisioned saving proportionately more state dollars than federal dollars.

To varying degrees, each state assumed it could slow the rate of growth in the cost of medical services and use some of those savings to serve more people. Tennessee planned the largest expansion and, in turn, required greater relative savings per person to finance its expansion. Hawaii had to stretch federal dollars

to serve more people but hoped that state funds previously used for SHIP could support some of the costs. Rhode Island planned a very limited expansion and depended less on managed care savings.

The states anticipated using many revenue sources in the projects:

- ***Medicaid Managed Care Savings.*** All three states initially assumed that mandatory capitated managed care will at least slow the rate of growth of expenditures per enrollee.
- ***Premiums or Copayments from Some Enrollees.*** All three states assume that there is some direct revenue from premiums from some expansion enrollees and/or reductions in capitation rates because participant copayments reduce the cost of care.
- ***Disproportionate-Share Hospital (DSH) Payments*** (Tennessee and Hawaii). Ending or reducing DSH payments frees up federal funds for program expansion.
- ***Reduction in Other State Health Programs*** (Tennessee and Hawaii). Other state-funded programs (such as SHIP, GA, or public health programs) were eliminated or reduced to help pay the State share of expenditures.
- ***Other.*** Tennessee also used certified public expenditures (the un- or underreimbursed costs of care for TennCare patients and eligibles in certain hospitals), provider taxes, charity care contributions (not federally matched), and other state or local revenue.

Types of expenditures for the demonstration programs include:

- ***Capitation Payments to MCOs.*** This is the main expenditure category in all three states. This may include medical MCOs, carve-out MCOs (for example, for dental or behavioral services), or supplemental payments to MCOs for high-risk patients. These include administrative costs and profits of the MCOs.
- ***Reinsurance*** (Hawaii and Rhode Island). The state finances reinsurance for high-cost cases, to reduce the risk for capitated MCOs.
- ***Interim Fee-for-Service Care*** (Hawaii and Rhode Island). Fee-for-service care is paid directly by the state during the gap period before a client selects an MCO.
- ***Supplemental Payments or Pools*** (Hawaii, Rhode Island, and Tennessee). These include special funding pools negotiated by the state to help support special types of vulnerable providers (for example, teaching hospitals or FQHCs), and to pay for care of expansion enrollees during their first 30 days of enrollment.
- ***Administration.*** This includes state staff, contractors, and data system support for the new programs.

Table VI.2 shows the budget assumptions for each project, as portrayed in the state applications. While actual experience makes the original estimates out of date, these show the patterns each state envisioned. More recent budget estimates were not always available to us.

Hawaii assumed that its demonstration would substantially reduce state expenditures over the life of the project but that federal expenditures would be roughly the same as without a demonstration project. The reduction in state expenditures was assumed because its program essentially would get a federal match for SHIP and GA funds previously paid only by the state. The state assumed that it could slow the overall pace of expenditure growth from 15.6 percent without reform to 11.9 percent with QUEST.

Rhode Island assumed that RIte Care would be a little more expensive at first but would yield very slight savings over the course of the project. The state hoped to attain a modest reduction in expenditure growth. As discussed in Chapter III, the state wanted to slow program growth, but a larger priority was to increase primary care expenditures and decrease hospital expenditures.

Tennessee projected it would be able to reduce the overall rate of growth of expenditures from 17.5 percent per year to an average 8.3 percent per year. In its first year, TennCare would cost the same as Medicaid, but it would be much less expensive by the final year.

2. Budget Neutrality Rules

In approving an application, HCFA sets rules for monitoring budget neutrality. Federal payments are capped in one of two ways (Trieger 1995):

1. ***Aggregate Spending Targets.*** These are limits on the total level of federal matching dollars over each of the 5 years of the demonstration, regardless of the number of people served or services rendered. The aggregate limit is a maximum, not a guarantee, and it accounts both for the expected changes in enrollees under predemonstration rules and the costs of medical services. This approach provides more flexibility to the state but also increases its level of financial risk. Tennessee uses this approach.

2. ***Per-Capita Targets.*** These are limits on the average federal expenditure per actual Medicaid-eligible enrollee, with an inflation adjustment for each year. To pay for an expansion group, the state must spend less than this level per Medicaid-eligible enrollee and

TABLE VI.2

ORIGINAL BUDGET ASSUMPTIONS FOR DEMONSTRATIONS IN HAWAII, RHODE ISLAND, AND TENNESSEE
(In Millions of Nominal Dollars)

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Growth Rate'
Hawaii (Demonstration Only--Includes Funds for State-Only Programs such as SHIP)							
Without Reform							
	Q 3 and 4. 1994	1995	1996	1997	1998	Q1 and 2. 1999	
Federal	45	104	119	137	157	90	
State	72	167	194	225	262	152	
Total	117	271	313	362	419	243	15.6%
With Reform							
Federal	54	107	119	133	150	84	
State	50	107	119	133	150	84	
Total	105	214	239	267	299	168	11.9%
Rhode Island (Demonstration Only)							
Without Reform							
	Q 4, 1994	1995	1996	1997	1998	g 1 to 3. 1999	
Federal	16	69	73	78	81	64	
State	14	60	63	67	70	55	
Total	30	129	136	145	152	119	5.7%
With Reform							
Federal	16	70	73	77	80	63	
State	14	61	63	66	69	54	
Total	31	131	137	143	149	117	4.5%

TABLE VI.2 *(continued)*

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Growth Rate*
Tennessee (Includes all Medicaid and TennCare, Including Long-Term Care)							
Without Reform							
	FY 1994	FY 199.5	FY 1996	FY 1997	FY 1998		
Federal	2,108	2,461	2,887	3,401	4,015		
Stale	1,038	1,216	1,427	1,677	1,978		
Total	3,146	3,677	4,314	5,078	5,994		17.5%
With Reform							
Federal	2,108	2,282	2,473	2,635	2,778		
State	1,038	1,124	I.298	1,298	1,368		
Total	3,146	3,407	3,670	3,933	4,145		8.3%

SOURCE: State applications

NOTE: The budget years differ, depending on the assumed start date of the project and state fiscal year.

'Growth rate is the average annualized growth rate for total (federal and state) expenditures during the 5 years

FY = Fiscal Year; Q = Quarter

use the excess funds to support the expansion. This approach offers somewhat less flexibility to the state, but reduces its financial risk. (For example, if there is a recession and Medicaid-eligible participation rises, then total federal payments would rise.) The projects in Hawaii and Rhode Island use this approach.' Since all RIte Care enrollees could have been Medicaid-eligible enrollees through their 1902(r)(2) amendment, Rhode Island is not at risk for changes in the number of enrollees, only for the change in the per capita cost of care.[2]

Hawaii and Rhode Island both assumed that they would have enrolled persons eligible under 1902(r)(2) amendments if they did not receive approval for their Section 1115 demonstrations. This enabled them to increase their baseline federal cost estimates above the actual prior levels of federal cost. Federal baselines were increased above prior "actual" levels by assuming that upper-income children or pregnant women would have been eligible in regular Medicaid under Section 1902(r)(2) provisions. On a technical basis, these children or pregnant women are considered eligible under old Medicaid rules. They were called "hypotheticals" because their costs were included in the baseline even though they were not actually covered.

In all cases, states must continue to match federal payments (based on the standard Medicaid matching rate), but when they pass beyond the federal cap, the state becomes responsible for all the excess expenditures. Table VI.3 summarizes the budget neutrality rules for each state.[3] All of the budget neutrality rules are based on assumptions about expenditure growth that would occur without the demonstration (such as medical price inflation, utilization increases, or caseload growth). These

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'Aggregate and per-capita limits must be compared with caution because of measurement differences. For example, if a state expects a 10 percent caseload growth of Medicaid-eligibles and 5 percent growth in expenditures per enrollee, an aggregate limit for that state would permit 15 percent growth in expenditures. If the state had a per-capita limit, however, the level would be 5 percent, since the caseload growth is automatically covered.

*Only the 24-month extended family planning coverage for post-partum women could not have been covered under 1902(r)(2) rules.

[3]RIte Care budget neutrality assumptions also changed after the program began. The base year expenditure per enrollee was increased, but the inflation levels were decreased to 6 percent in 1995 and 4 percent in 1996- 1999.

TABLE VI.3

FEDERAL BUDGET-NEUTRALITY RULES

Characteristic	Hawaii	Rhode Island	Tennessee
Federal Target/cap	Per-capita limit, Based on the number of Medicaid-eligible enrollees, including 1902(r)(2) children. Per-capita limit is based on 1993 average expenditure, adjusted by consumer price index for medical care for Honolulu plus 4 percent.	Per-capita limit. Based on all enrollees, including 1902(r)(2). Per-capita limit is based on 1993 average expenditure, increased by 8 percent in 1994, 6 percent in 1995, and 4 percent per year in 1996 through 1999.	Aggregate limits. In millions of dollars, the annual and cumulative limits and margins are:
State Risk	State is at risk for expenditures for adult General Assistance and State Health Insurance Program-type recipients. All children are considered Medicaid-eligible under Ribicoff or 1902(r)(2).	Because the expansion group comprises 1902(r)(2) pregnant women or children, all enrollees are included as eligible under Medicaid rules (not as part of the expansion group).	

	Annual	Cumulative
Year 1	2,108	2,277 (+8%)
Year 2	2,283	4,654 (+6%)
Year 3	2,454	7,119 (+4%)
Year 4	2,594	9,628 (+2%)
Year 5	2,726	12,165 (+0%)

NOTE: Tennessee's limits include all portions of TennCare and Medicaid, including long-term care, in the aggregate cap. Hawaii's and Rhode Island's agreements are restricted to the demonstration projects.

assumptions are inherently difficult to validate. The General Accounting Office (1995d), has questioned whether some Section 1115 demonstrations are truly budget neutral. A long-term goal of this evaluation project is to assess the impact of the demonstrations on Medicaid expenditures, but there are divergent beliefs about what budget neutrality means and how to measure it.

3. Financing Problems

Preliminary information indicates that Tennessee and Hawaii had fiscal problems in their first year. QUEST participation exceeded the projected level of 110,000 enrollees and was over 150,000 by the end of the first year. Effective in Year 2, Hawaii began efforts to reduce participation and increase premium revenues. In April 1996, Hawaii made major program changes to limit spending. Tennessee collected fewer premiums than expected, claimed fewer certified public expenditures than expected, and was unable to secure other state funds needed for its share of the matching payments. Because of these difficulties in covering the state share, TennCare stopped enrolling uninsured people late in 1994 (this is discussed in the next section).

Rhode Island had the opposite problem. The state projected that 10,000 new pregnant women and children would be served, but fewer than 1,000 joined in the first year. Thus, the number was well below the state's projections, and relatively few uninsured people gained new coverage. In the second year, the state stepped up outreach efforts and proposed to cautiously expand eligibility for children.

D. ELIGIBILITY AND ENROLLMENT

As the programs started, enrollment-related problems were common, although they ameliorated over time. The size of the expansion and the schedule of implementation affected the scope of problems.

1. Eligibility Changes

a. Major Expansions

One of the major goals of these three states was to expand insurance coverage through expanded eligibility for Medicaid benefits.[4] Table VI.4 summarizes a couple of the pre-reform eligibility criteria and the eligibility changes implemented in 1994 under the demonstrations. Tennessee had by far the largest expansion: its prior Aid to Families with Dependent Children (AFDC) eligibility criteria were relatively low, and TennCare expanded to serve uninsured people of all incomes (although subsidies stopped at 400 percent of poverty). The program's designers intended to greatly expand insurance access, and the state added about 400,000 previously uninsured people. However, the shortage of state funds meant that enrollment of the uninsured was stopped in December 1994.[5]

Hawaii's expansion can be viewed as large or small. Although QUEST serves people up to 300 percent of poverty, the state already had state-funded programs that served people up to 300 percent of poverty: the GA program, which provides cash assistance and Medicaid-type benefits to certain very low-income people not categorically eligible for AFDC, and SHIP, which offered a limited health insurance package to uninsured people with incomes up to 300 percent of poverty. SHIP had capped funding, however, and people could join only during specific times of the year. QUEST appears to have enrolled far more people than SHIP covered. Hawaii made major changes in QUEST eligibility criteria in April 1996 to control participation and expenditures.

RIte Care increased income eligibility for pregnant women and children under age 6 to 250 percent of poverty and extended family-planning services to women 2 years after delivery (compared with

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[4]By contrast, many of the later applications for Section 1115 waivers include no or very modest eligibility expansions.

[5]However, in Tennessee those eligible under old Medicaid rules and those deemed "uninsurable" are still being enrolled, as are people losing Medicaid eligibility who choose to enroll as uninsured. People enrolled as "uninsured" are grandfathered and may continue to participate as long as they are eligible.

TABLE VI.4

CHANGES IN ELIGIBILITY POLICIES

Characteristic	Hawaii (prior to April 1996)	Rhode Island	Tennessee
Examples of 1993 Income Eligibility Levels:*			
Aid to Families with Dependent Children (family of three)	• 63 percent of poverty	• 56 percent of poverty	• 43 percent of poverty
Pregnant women and infants	• 185 percent of poverty	• 185 percent of poverty	• 185 percent of poverty
Main Eligibility Expansions Under The New Initiatives (1994)	• People with incomes below 300 percent of poverty are eligible for QUEST, if they are not covered under the state's employer mandate in the Prepaid Health Care Act. (Employer mandate covers full-time workers.) • May not be disabled and under age 65 • People up to 300 percent of poverty were previously covered by state-funded General Assistance and State Health Insurance Programs	• Eligibility for pregnant women increased from 185 to 250 percent of poverty. • Eligibility for children under age 6 increased from 133 to 250 percent of poverty • Women eligible for extended family-planning benefits for 2 years after delivery • Proposed raising age for children to under age 8	• People uninsured on a set date may join • State subsidizes people up to 400 percent of poverty. People above that income may join. • "Uninsurables" are those who cannot get private insurance because of health problems. • "Uninsured" are those whose employers do not offer insurance. • Stopped enrolling uninsured as of December 1994, but continue to enroll uninsurables, Medicaid-eligibles, and people losing Medicaid
Other Important Eligibility Changes	• No assets test for expansion groups • Retroactive coverage limited to 5 days	• No assets test for expansion groups • Still provide retroactive coverage for 3 months • 6 months guaranteed coverage in managed care	• No assets test for expansion groups . No retroactive coverage
Premiums and Copayments	Sliding-scale premiums charged for people above 133 percent of poverty in Year 1 (lowered to 100 percent of poverty in Year 2). Limited copayments.	Those in expansion group can choose either point-of-service copayments or modest premiums.	Sliding-scale premiums, deductibles, and copayments for those above 100 percent of poverty. Participants select high- or low-deductible plans.[b] No copay requirement for preventive care.

"July 1993 eligibility criteria based on National Governors' Association Center for Policy Research 1993.

[b]High-deductible plan is no longer an option.

60 days).[6] Rhode Island also required that MCOs, as a condition of contracting, make insurance coverage available to some other groups (such as older siblings of expansion children and people losing RIte Care eligibility), although these groups are not part of RIte Care and receive no public subsidy.

Each state worried that publicly subsidized health insurance could erode private employer-based insurance. Tennessee required that the expansion group enrollees not be insured for several months before applying.[7] Rhode Island required that expansion enrollees be un- or underinsured and could not have refused reasonably priced insurance recently. In Hawaii, QUEST was denied to employees who had mandatory coverage under the state's Prepaid Health Care Act, although dependents were eligible for QUEST. All three states dropped assets tests for the expansion categories. However, assets could still be used to determine eligibility for those eligible for Medicaid prior to the demonstration (for example, AFDC, SSI, or Medically Needy eligibility).

b. Other Eligibility Changes

Retroactive coverage up to 3 months prior to application is standard in Medicaid; this is problematic in managed care, however, since the care occurs before a person is enrolled in a plan. As Table VI.4 shows, Tennessee and Hawaii sharply limited retroactive coverage. Rhode Island has'federal permission to waive 3-month retroactive coverage but has not implemented that waiver.

Guaranteed coverage is a related issue. MCOs traditionally have complained that rapid turnover of Medicaid clients, particularly "churning" (such as temporary termination from AFDC because paperwork is not submitted on time), makes it difficult to manage a person's care. Rhode Island guaranteed 6 months of eligibility in RIte Care. Tennessee covers AFDC-eligible and medically needy-eligible enrollees for

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[6]Rhode Island also subsidizes insurance for pregnant women between 250 and 3 50 percent of poverty, but this subsidy is considered separate from the demonstration and was not matched by federal funds,

[7]TennCare required that uninsured enrollees did not have employee- or government-sponsored insurance on March 1, 1993 and did not turn down employer- or government-sponsored insurance after that date. In 1995, this date was changed to July 1, 1994.

12 months. Hawaii does not have a guarantee, but does attempt to reduce churning by more careful review of terminated cases. For example, if a person is terminated from AFDC, the case may be considered pending for a few weeks, instead of immediately being terminated (in case the person reapplies or is subsequently determined eligible).

c. Premiums and Cost Sharing

One of the most distinctive features of traditional Medicaid is that it has generally been free to beneficiaries (nominal copayments are allowed). In contrast, each demonstration program requires that some expansion group enrollees pay either premiums or copayments. Both Hawaii and Tennessee exempted very-low-income people from premiums but imposed sliding-scale premiums that rise with income for others. People at the top of the income eligibility range pay the full premium. Rhode Island let expansion group participants choose either limited premiums or copayments; most selected copayments.

Tennessee experienced problems with premium billing and collection in the first year. Through administrative errors, premium notices were not sent to many clients for 6 months. In the second year, the state dropped more than 80,000 clients for nonpayment. Hawaii had fewer problems with premium nonpayment, although it also dropped nonpayers. In 1995 and again in 1996, Hawaii increased premiums and tightened accounting rules to limit participation and increase revenue.

Medicaid regulations prohibit charging mandatory categorically needy people copayments or deductibles for most services under managed care, and this cannot be waived. Nonetheless, each state uses copayments or deductibles for expansion group clients to some extent. TennCare has a relatively extensive schedule of income-related deductibles and copayments. Hawaii and Rhode Island have relatively limited copayments, sometimes targeted to specific services (such as copayments for hospital admissions).

2. Enrollment Procedures

In all the states, enrollment-related problems were among the most visible difficulties encountered in the first year. Many of the problems were caused by the unfamiliarity of the new program and of managed care to both clients and providers. These problems diminished in time as people became familiar with the programs. Nonetheless, many of the problems were avoidable and occurred at least partly because of inadequate planning or flawed execution, which were the costs of rapid implementation. Table VI.5 summarizes key enrollment procedures.

a. Eligibility Processing

Since AFDC and other groups eligible prior to the demonstration still exist in each state, some eligibility processing, related to AFDC or old Medicaid rules, still occurs in welfare offices. In Rhode Island, the expansion groups also apply at welfare offices. For their large expansion groups, Tennessee and Hawaii developed new procedures. TennCare used the Farm Bureau, a private insurance company, to verify insurance status and incomes of the uninsured applicants and to establish their premium payments* This process normally took about 45 to 60 days, including 30 days allowed for the applicants to respond to a request for more information. TennCare also simplified the application form for the expansion groups by making it only one page, including MCO selection. Hawaii shifted responsibility for QUEST eligibility away from welfare offices to new Med-QUEST offices. Appointment delays of 3 months were normal at the start, although the average waiting time for an appointment dropped to 2 or 3 weeks by the end of the first year.

b. Enrollment into MCOs

The most important change was that eligibility staff members were now also responsible for ensuring that clients selected or were assigned to MCOs. In all three states, enrollees in every area could choose

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'Subsequently, the TennCare Bureau took this process over from the Farm Bureau.

TABLE VI.5

KEY ASPECTS OF FIRST YEAR ENROLLMENT PROCEDURES FOR DEMONSTRATION PROGRAMS

Characteristic	I lawaii	Rhode Island	Tennessee
Eligibility Determination for Expansion Groups	Nonwelfare cases processed by Med-QUEST eligibility offices. Usually requires an in-person eligibility determination session	Encourage in-person applications and enrollment counseling, but mail applications are permitted	Mail applications sent to state. Private contractor verifies and determines eligibility and premium levels.
Enrollment Into MCOs, Counseling, and Marketing	• Medical and dental MCOs selected after eligibility is determined . Whole family must select same medical and dental MCOs • Relatively little counseling is provided by QUEST staff. • Standard brochures distributed describe each MCO. • Relatively strict regulation of MCO marketing, with limited direct marketing. No door-to-door marketing or marketing representatives	• MCO selection made after eligibility is determined • Whole family must select same MCO • RIte Care staff provide nonbiased counseling and education about managed care, including standard plan information. • No direct marketing of any kind by MCOs permitted	• SSI-eligible enrollees select MCO after eligibility is determined, but all others select MCO in-advance on the application form • Whole family must select same MCO • State does not offer counseling, but information is available through hot lines. • Standard package provides information about MCOs . No regulation of MCO marketing initially. Door-to-door marketing and marketing representatives permitted.
Auto-assignment (for people who do not select an MCO in time)	. Auto-assignments favor low-cost plans. • Auto-assignment rate about one-third at first, dropped to 10 to 15 percent	• Auto-assignments favor low-cost plans. * Auto-assignment rate 6.5 percent in February 1996.	• Auto-assignments made on the basis of prior affiliations or proportionate to distribution of those who select MCOs • Auto-assignment rate about 40 percent initially
Timing	Mass enrollment occurred before August 1, 1994	Enrollment for Medicaid-eligible enrollees phased in during first year. Expansion group enrollees could join before August 1, 1994.	Mass enrollment occurred before January l, 1994

MCO = managed care organization.

between at least two plans and often had more choices (especially in urban areas). In all three states, a family can choose an MCO (in Hawaii, both a medical and dental MCO). Unless that MCO has reached its maximum caseload level, the state enrolls the family in that plan and notifies the MCO. If a family does not choose an MCO in a set period of time (typically 2 weeks), or if the plan selected is full, the state automatically assigns (or auto-assigns) an MCO. The MCO subsequently sends membership cards and new-member information packages (including lists of participating providers) and asks new members to select primary care providers.[9]

One of the most common complaints that consumers and physicians voiced was that little counseling about MCO selection or education about managed care was provided to enrollees. Effective counseling requires more enrollment staff members or counselors, and states did not always make the necessary investments. Table VI.5 compares the levels of patient education provided by each state and MCO marketing rules. Tennessee and Hawaii provided almost no standard oral counseling about MCO selection or about managed care, although written materials were available. Rhode Island staff initially offered individualized counseling, but shifted to group counseling sessions in urban areas to meet demand; the state also used a videotape describing managed care. One important marketing tool permitted in each state was that physicians, community health centers, or other providers could indicate their MCO affiliations and could encourage their patients to select those plans for continuity of care.

Both Tennessee and Hawaii had mass enrollments by mail before the programs began; these program startups were usually described as chaotic, Both states encountered major problems with the mass enrollments because of confusion about the new policies and because the MCOs and their provider networks were not fully established. Tennessee sent out its ballots before the MCO contracts were signed: the ballots included 20 plans, but only 12 MCOs signed contracts, so some clients selected nonexistent

[9]In Tennessee, primary care gatekeepers were not initially required for those who selected preferred provider organizations (PPOs). In Rhode Island, applicants could select a primary care provider at the same time they selected an MCO.

plans. Neither Tennessee nor Hawaii was able to provide information about the MCOs' provider networks, so clients could not readily determine which plans their doctors belonged to. Furthermore, there were too few program staff members and telephone lines to answer questions, and the staff members were inexperienced. Because of the early confusion about MCO selection and assignments, both states allowed clients to switch MCOs soon after implementation began.

RIte Care phased in managed care enrollment over the first year of the program. Families were shifted to managed care when their cases came up for welfare redetermination or when they signed up for program benefits. While there were similar problems of confusion, especially at the beginning, they appeared to be less severe than those in Tennessee or Hawaii.

c. Auto-Assignment

The goal in all states was that members would select an MCO on the basis of perceived quality, availability of certain doctors, price, or other factors. However, some people do not select a plan because they have no preference (perhaps because the family is healthy and has no strong attachment to a doctor) or because they do not understand the choices. The auto-assignment rate is a measure of whether clients were informed and understood the choices open to them. As Table VI.5 shows, Tennessee and Hawaii began with a high level of auto-assignment, although in Hawaii this dropped by the end of the year. Rhode Island had a relatively low rate of auto-assignment.[‘”]

d. Enrollment Data Systems

Each state had underlying problems with its data systems (both computer systems and general communication protocols) in the first year. Medicaid Management Information Systems (MMISs) were not set up to deal with enrollment in managed care plans or to keep track of premium payments. Administrative drop/add eligibility systems and retroactive additions or terminations, common for welfare-

‘We did not have good data about Tennessee’s auto-assignment rate after initial implementation.

related programs, were confusing to MCOs. Thus, states and MCOs often disagreed about who was covered and for what period of time. Systems in all states had problems automatically adding newborns to family eligibility files.

e. Other Enrollment Problems

Tennessee's application-by-mail system was convenient but posed unique problems. Applicants did not know the price of premiums when they mailed in their applications. In addition, the system was probably more susceptible to abuse. Representatives of one MCO allegedly signed up many fictitious cases; this was picked up sometime after their enrollment. In Hawaii, the long enrollment delays meant that many families were not enrolled in MCOs for a few months. This led to problems in providing medical care during the gap periods between application, eligibility determination, and MCO enrollment, and in determining who was responsible for paying for care in those periods. The fee-for-service gap was an issue in each state but appeared more serious in Hawaii because of the enrollment backlog. Many of Rhode Island's problems were related to its new MMIS system; providers and clients had difficulty verifying a person's eligibility status on a timely basis.

E. SERVICE COVERAGE

The services offered were similar to, or broader than, prior Medicaid benefits.

All of the demonstrations maintained or enhanced their benefit packages for acute and preventive services; none included long-term care in the reforms. TennCare eliminated service limits on physician services, home health, and prescriptions. TennCare also covered adult inpatient psychiatric services, which were not previously covered by Medicaid. In QUEST, groups previously covered under SHIP got much broader benefits, although those covered by Medicaid and GA had relatively little change." An important

"For example, SHIP had a 5-day inpatient hospital limit under fee-for-service.

expansion of services in Rhode Island was the extended family-planning benefit. Rhode Island also offered an innovative transportation benefit: a contract with the state transportation agency provided bus passes to help clients get to their appointments.

F. MANAGED CARE

Despite their limited experience with Medicaid managed care, the states were able to contract with capitated managed care plans quickly. The MCOs that took the most members were typically network-style plans. We are unable to assess the quality of care provided at this time or predict the long-term stability of the plans.

Each demonstration marked a significant movement away from Medicaid's traditional, fee-for-service health care systems toward capitated, managed care arrangements. The shift to managed care was fueled by states' hope that capitated payments would allow them to better estimate and control the rate of Medicaid expenditure growth. States believed that MCOs could save money by emphasizing primary and preventive care, reducing the length of inpatient hospital stays, and curbing unnecessary use of emergency room services and specialists. Moreover, states felt that managed care could improve enrollees' access to primary care services and the continuity of their care.

Perhaps the most important finding is that despite the challenges and problems, all three states succeeded in forming broad-based Medicaid managed care systems in a short time period. While it is too early to assess these systems' performance in terms of saving money, maintaining quality of care, and retaining an adequate network of providers, data from the site visits sheds light on the similarities and differences in the states' approaches to expanding managed care.

1. Managed Care Before and After the Demonstrations

A factor that could affect the capacity for managed care is the level of overall (that is, including commercial plans) managed care in each state before the demonstrations. Table VI.6 shows that Hawaii and Rhode Island had relatively broad managed care markets. Both had private HMO membership rates

TABLE VI.6

PREDEMONSTRATION MANAGED CARE MARKET CHARACTERISTICS

Characteristic	National	Hawaii	Rhode Island	Tennessee
1993 Private HMO Market Penetration[a,b,c,d]	• Number of HMOs: 54.5 • Percent HMO Penetration: *17.4*	• Number of HMOs: 6 • Percent HMO penetration: *22.3*	• Number of HMOs: 3 • Percent HMO Penetration: *25.9*	• Number of HMOs: 11 • Percent HMO Penetration: *5.7*
1993 Medicaid Managed Care Market'	. 26 1 programs operating • Managed care models range from primary care case management to fully capitated HMOs. • 17 percent of nonelderly Medicaid enrollees participating	• Program offered in two counties • Voluntary enrollment • Kaiser Permanente, fully capitated HMO • AFDC and AFDC-related groups eligible • Four percent of nonelderly Medicaid enrollees participating	• Statewide program • Voluntary enrollment • Harvard Community Health Plan of New England, fully capitated HMO • AFDC and AFDC-related groups eligible • Less than 1 percent of Medicaid enrollees participating	• Program offered in 16 counties • Voluntary enrollment • Primary care network, fully capitated HMO • AFDC and AFDC-related groups eligible • Four percent of nonelderly Medicaid enrollees participating

[a]SOURCE: Group Health Association of America's *1994 National Directory of HMOs*.

[b]HMO data include capitated managed care plans, including group-model HMOs and Individual Practice Association (IPA) network-style HMOs, but not preferred provider organizations or related plans.

'HMO location is based on the location of the organization's headquarters. HMOs in multistate areas may draw members from neighboring states.

[d]The percent penetration figure is based on the total insured population,

[e]SOURCE: Health Care Financing Administration (1993).

AFDC = Aid to Families with Dependent Children,

above the national average, while Tennessee's HMO penetration rate was below the average. Prior to the demonstrations, Medicaid managed care in each state was limited to voluntary programs with a very small number of plans. No state had more than 4 percent of its Medicaid enrollees in managed care before 1994.

2. Managed Care Under the Demonstrations

The managed care systems that evolved in the first year of the demonstrations varied considerably in size, scope, and form (see Table VI.7). However, four common patterns emerge from the first-year case studies.

First, the states were able to attract MCOs and, in turn, the MCOs were able to attract health care providers to establish managed care systems throughout the state quickly. Through cooperative efforts between states and MCOs, the states could offer at least two plans in every area of the state. Despite initial risks and misgivings, MCOs were willing to contract with states, and providers were willing to contract with the MCOs. However, each state still had areas where access problems were apparent.

Second, the expansion of Medicaid managed care affected the overall levels and structure of managed care in the states. The dramatic increase in Medicaid managed care also increased the overall percent of state residents in managed care. For example, TennCare alone nearly tripled the HMO penetration rate in Tennessee (see Chapter V). The demonstration programs were the impetus for the development of new MCOs (AlohaCare and Straub in Hawaii; Neighborhood Health Plan in Rhode Island; and Vanderbilt Health Plan, Total Health Plus, Phoenix, and TLC in Tennessee) or significant expansion of existing companies (for example, Access MedPlus in Tennessee). In Tennessee and Hawaii, the new Medicaid MCOs represented the first exposure of many physicians to managed care plans.

Third, the plans that enrolled the most new members were Independent Practice Association (IPA) or PPO models (using provider networks), not group-model HMOs. Group-model HMOs usually capped the number of Medicaid or demonstration enrollees they would take. Network plans could accommodate more expansion by signing up more providers. However, the network-style plans often practiced a more

TABLE VI.7

KEY FEATURES OF MEDICAL MANAGED CARE ORGANIZATIONS (MCOs) IN THE DEMONSTRATION PROGRAMS

Characteristic	Hawaii	Rhode Island	Tennessee
Number of participating MCOs	5	5	12
Type and Number of MCOs	Group-model HMOs 2 Independent Practice Association model 2 Federally Qualified Health Center-based 1	Group-model HMOs 1 Independent Practice Association model 3 Federally Qualified Health Center-based 1	Preferred Provider Organization" 5 HMO 7
Percentage Enrolled in MCOs (up to five largest)[b,c]	Hawaii Medical Service Association (HMSA) 65% Queen's Hawaii Care 16% AlohaCare 11% Kaiser Permanente 5% Straub 3%	United Health Plans 51% Neighborhood Health Plan of Rhode Island 30% Health Maintenance Organization-Rhode Island 12% Harvard Community Health Plan 6% Pilgrim Health Plan 1%	Blue Cross/Blue Shield 50% Access MedPlus 24% HealthNet 6% OmniCare Health Plan 5% Preferred Health Partnership 5%
Geographic Service Areas	HMSA Statewide Queen's Four counties AlohaCare Three counties Kaiser Two counties Straub Three counties	All plans are statewide.	Blue Cross/Blue Shield Statewide Access MedPlus Statewide HealthNet Four regions OmniCare Two regions Preferred Five regions

"In TennCare, a preferred provider organization was a restricted network of providers that accepted discounted fee-for-service payments. Primary care gatekeepers were not required, and clients could not select providers outside the network. This differs from the standard definition of a preferred provider organization.

[b]Percentages may not total 100 percent because of rounding or because only the largest MCOs are listed.

'Enrollment distributions as of April 1995 for TennCare, March 1995 for Quest, and November 1995 for RIte Care

rudimentary form of managed care: extensive practice guidelines and physician profiling were usually lacking, and physicians and other providers were still learning to navigate the system. Although some physicians received capitation payments, most physicians were paid through discounted fee-for-service arrangements. PPOs in TennCare were particularly loose and did not even require primary care physicians as gatekeepers. Managed care in the network MCOs may become more sophisticated in time. For example, Tennessee is requiring that its PPOs convert to HMOs and adopt gatekeeper systems by January 1997.

Fourth, although initial managed care arrangements could be made quickly, some components were not in place when implementation began. The monitoring and data systems needed to maintain an effective managed care system were not usually in place at the date of implementation. In each state, MCOs were in the process of submitting quality assurance/improvement plans to the states several months into the demonstrations. Encounter and other automated data systems were still being developed or tested at the end of the first year. One MCO in Tennessee had severe problems because it lacked a functional computer claims-processing system several months after the start of the program. Other MCOs, particularly the new ones, also appeared to have problems paying claims at first.

3. Contracting and Capitation Rate Setting

Two distinctive approaches to MCO contracting were developed. Hawaii and Rhode Island followed a "managed competition" approach: a competitive bidding model under rules set forth by the state. Both states issued requests for proposals (RFPs) for plans and distributed historical Medicaid utilization data to help applicant firms develop capitation bids. The state agencies worked with contracted actuaries to develop acceptable rate ranges, based on prior Medicaid utilization and payment levels, as well as assumptions of managed care savings. After receiving initial bids from MCOs, both states negotiated with MCOs to bring prices into the acceptable rate range. The negotiations usually led to substantial decreases in the capitation rates for each MCO, compared with their initial bids. A result of the bidding process is

that different MCOs earn slightly different capitation rates in these two states. MCOs with lower rates get more auto-assigned members.[12]

In comparison, Tennessee announced that it was taking applications, and set fixed capitation rates that were offered to all plans.[13] There was no formal RFP, although the word was disseminated widely. The state agency developed the capitation rates on its own; an outside accounting firm later reviewed the process and described it as actuarially sound. Chapter V describes the state's rate-setting calculations in more detail, including the deep discounts built into the computations.

In the three states, several other rules specified terms of participation by MCOs:

- Each state required that MCOs accept capitated payments. However, each state took measures to buffer MCOs' risks in the first year. Rhode Island and Hawaii sponsored reinsurance plans for the MCOs, and TennCare offered supplemental payments to MCOs with high-risk cases.
- Hawaii and Rhode Island required that MCOs use primary care provider gatekeepers. Tennessee permitted PPOs (which do not require primary care providers) to participate.
- Each state required that each MCO offer the standard benefit package, although some slight variations were permitted.
- Rhode Island required that all MCOs be licensed as an HMO under state. regulations.[14] Hawaii had no HMO regulations. Tennessee's newly formed PPOs were unregulated. In Year 2, the Department of Commerce and Insurance was given authority to monitor MCOs in TennCare.
- Rhode Island required that plans be available statewide, while plans in Tennessee and Hawaii could have limited service areas.
- Rhode Island required that all physicians in the MCO take RIte Care clients (this was called "mainstreaming"). This was not universally required in Tennessee, but the large Blue Cross/Blue Shield plan required that physicians treating state employees also take TennCare

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'*Auto-assigned cases are viewed as desirable, because prior research suggests that they have lower medical expenditures (since they are less attached to physicians) and are healthier (Hurley et al. 1993).

[13]Using economic terminology, Tennessee was using monopsonistic power as a major purchaser of health care to set the price, compared with the managed bidding system used in the other two states.

[14]The HMO licensing requirement delayed entry of one new MCO for a few months.

clients (this was called "cram-down" in the state). In Hawaii, physicians' QUEST contracts were independent of other arrangements.

In Tennessee, 12 of 20 potential MCOs executed TennCare contracts. The state rejected some plans because of financial concerns; some other plans withdrew because they felt the capitation rates or contract length were not adequate. Rhode Island rejected two bids--one because it did not meet minimum scoring requirements and the other because the submission was incomplete. QUEST administrators did not reject any of the medical or dental MCOs that submitted proposals, although one behavioral plan was rejected.

4. Payment Adequacy and Capitation Rates

The level of capitation rates is a critical element in determining whether managed care saves the states money; it also affects the willingness of MCOs and health care providers to participate. How do these rates compare with predemonstration Medicaid payment levels, and how do they compare across states?

Although comparisons are simple conceptually, they are complex in reality. The populations and services covered under the plans vary from state to state, and the services changed somewhat before and after implementation. Finally, data sources about predemonstration Medicaid payment levels are imperfect. In Table VI. 8, we have assembled data on 1993 (predemonstration) Medicaid physician and inpatient hospital payment levels, 1993 Medicaid expenditures per recipient, and 1994 (postimplementation) MCO capitation rates. The data in Table VI.8 are imperfect, and readers should be cautious in drawing conclusions about comparative status.

We can see from the top part of the table that, in 1993, Tennessee had some of the highest Medicaid physician payment rates in the nation, while Rhode Island had among the lowest. While Tennessee physicians were upset that MCOs often had low payment rates, TennCare may have brought them closer to the national average. In contrast, Rhode Island physicians liked RIte Care payment rates, which were

TABLE VI.8

MEDICAID/DEMONSTRATION PROGRAM PAYMENT MEASURES BEFORE AND AFTER IMPLEMENTATION

	National	Hawaii	Rhode Island	Tennessee
1993--Pre-Implementation				
Physician payment levels (ratio of Medicaid to Medicare as a percentage)"	73%	86%	47%	97%
Hospital payment levels (Medicaid payments as a percentage of associated costs)[b]	93%	87%	88%	131% (84%)
Federal fiscal year 1993 Medicaid monthly acute-care expenditures per recipient'				
Nondisabed adults	$150	$155	$102-128	$142
Nondisabled children	$82	$93	$50-63	$85
Disabled	$373	Not applicable	Not applicable	$253
1994--First Year of Implementation				
Average managed care organization capitation rate per member per month[d]	Not applicable	$188	$115	$101
Geographic adjustment factor for 1994 Medicare physician fee schedule'	1.000	1.041	0.991	0.912

[a] SOURCE: Norton 1995. This represents a weighted average for a number of common procedures, based on a state survey.

[b] SOURCE: Prospective Payment Commission 1995, based on American Hospital Association survey data. It is believed that levels include all Medicaid revenues, including disproportionate-share hospital, which should overstate net payments. For Tennessee, the number in parentheses is the level with provider tax payments treated as an offset to regular payments.

'SOURCE: Liska et al. 1995. Recipients are unduplicated people who use medical care in a year. These are based on merged and edited HCFA-2082 and HCFA-64 data, reported by the states for federal fiscal year 1993. Disproportionate-share hospital payments are not included. Rhode Island recipient data are crude estimates because the state did not submit a HCFA-2082 report, partly because it lacked an Medicaid Management Information System. Alternative data suggest that recipient levels were actually much lower, and expenditures per recipient were about 20 to 25 percent higher. Therefore, the lower end of the range for Rhode Island is based on the reported data, and the upper-bound estimates represent an increase of 25 percent over the lower bound figure, as a rough adjustment.

[d] The Hawaii rate includes medical and dental rates for the largest plan for adult and child enrollees for August 1994 to June 1995. The Rhode Island rate is for adult and child enrollees, excluding dental care, for August 1994 to January 1996. The Tennessee rate applies for all enrollees for January to June 1994 and includes all services, but not supplemental payments. The supplemental payments appear to have averaged $3 per enrollee, per month

'SOURCE: Health Care Financing Administration 1994. This illustrates geographic price differences and may not be directly applicable for these programs

usually higher than Medicaid rates. Hawaii physicians reported that QUEST payment rates were about the same as Medicaid payment levels." To examine expenditure differences, we concentrate on nondisabled adults and children, populations in common in each state. While the disabled and aged are relevant for TennCare, they are not included in the other two programs. In 1993, the overall average acute-care Medicaid expenditures per recipient for Tennessee and Hawaii were relatively close to the national average levels, while Rhode Island's expenditures appeared to be below the national average.[16]

After the demonstrations began, the programs shifted to MCO capitation rates (also shown in the table). Across time, MCO capitation rates cannot be directly compared with the prior expenditures per recipient because of (1) population differences (TennCare includes the disabled and aged in its capitation rate), (2) small differences in services, (3) temporal price differences related to inflation, and (4) measurement differences.[17,18] State-specific savings related to managed care can be estimated with budget assumptions provided by the states. Tennessee, through its extensive discounting, designed capitation rates that were roughly 40 percent less than the expected fee-for-service equivalents (see Chapter V). Hawaii indicated that QUEST expenditures per person (including capitation payments, reinsurance, and residual fee-for-service costs) were 12 percent lower than the amounts that would have

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[15]In each state, payment rates and methods vary among MCOs. Because of the proprietary nature of MCO-physician relationships, we could not get good data about MCOs' physician payment rates, although respondents could describe general patterns. In two states, we asked MCOs to complete questionnaires about physician payment methods and levels and promised complete confidentiality, but we received too few responses to be usable.

[16]Rhode Island enrollment data are flawed because of reporting problems. Alternative data sources suggest that actual enrollment was lower and that expenditures per recipient were roughly 20 to 25 percent higher,

"For example, the 1993 Medicaid acute-care expenditures for Rhode Island include dental care, but the 1994 capitation rates for RIte Care do not.

[18]The 1993 expenditures per recipient are based on unduplicated recipients in a year, while the capitation rates are based on enrollment in a given month. Usual turnover rates in Medicaid suggest that an enrollee is only on the program for 7 to 9 months in a 12-month period. On the other hand, during a given year, about 80 to 90 percent of enrollees receive medical services.

been spent under fee-for-service (see Table IV.2). Rhode Island data indicate that it saved about 6 percent through the shift to RIte Care (see Chapter V). Because these savings estimates are based on assumptions of the alternative fee-for-service expenditures, they are not definitive estimates.

The capitation payments shown in Table VI.8 should not be directly compared across states. The most important difference is that Tennessee's rate includes the disabled, whose care is much more expensive, while Hawaii's and Rhode Island's rates include only adults and children. There are also slight differences in the services offered; Rhode Island's rate excludes dental care. The Tennessee rate was for early 1994, a year before the Hawaii and Rhode Island programs' rates, so there are inflation-related differences. Finally, underlying price differences that should affect the capitation rate differences exist among the three states. To illustrate this point, the bottom row of the table presents geographic adjustment factors for Medicare's physician fee schedule. These data suggest that underlying differences in the price of health inputs in Hawaii make medical care about 14 percent more expensive than in Tennessee, while Rhode Island is about 9 percent more expensive

Overall, it appears that Tennessee's capitation rates were the lowest of the three, followed closely by Rhode Island. Hawaii had the highest rates."

5. Changes After the First Year

After the first year, states made modest changes in the MCO contracts and rates:

- ***Tennessee*** In July 1994 and July 1995, the state increased capitation rates by 5 percent, as planned. In September 1995, new agreements were signed with MCOs that increased the capitation rates 4.5 percent above the regular annual increases. Other changes: MCOs will

[19]TennCare and RIte Care rates can be compared for specific groups. For infants, the TennCare capitation rate was $114 per month (after adjustments), while the average RIte Care rate was $247. TennCare paid $40 per month for children ages I to 13, while RIte Care paid an average of $48 for children ages 1 to 14. TennCare paid $73 for males ages 14 to 44, while RIte Care paid $70 for males ages 15 to 44. The rates for adult females were not comparable because RIte Care had a separate payment for delivery costs. Including the TennCare supplemental payments would increase rates about $3 per month.

provide patient education newsletters, will participate in the state's information clearinghouse for providers, and MCO payments for claims will be expedited. In addition, the original contracts require PPOs to convert to HMOs and use gatekeepers by the beginning of 1997.

- ***Hawaii.*** In contrast to the expected increase in MCO capitation rates (planned to begin July 1995), rates were renegotiated, and most decreased slightly. Furthermore, the initial 2-year contracts were extended another few months.

- ***Rhode Island.*** Contracts and capitation rates were extended through February 1996. The state planned to make changes (such as modifying rates and requiring that MCOs buy reinsurance on the commercial market, instead of through the state).

The additional increases in capitation rates in Tennessee and the rate reductions in Hawaii indicate that the differences in rates across states are narrowing with time.

G. PROVIDER ISSUES

The managed care systems required rapid development of health care provider networks. The reaction of health care providers to the new programs varied considerably by state and type of provider.

The adequacy of managed care depends on the ability of MCOs to attract, work with, and retain health care providers. To understand provider issues, we met with provider representatives (for example, medical, hospital, and primary care associations) and with urban and rural providers. We conducted focus groups of participating physicians in the urban areas and spoke with state and MCO representatives.

1. Recruitment of and Contracting with Providers

MCOs' approaches to recruiting and contracting with providers varied, depending on state rules and the nature of the MCOs. Group-model HMOs were reluctant to expand much for the demonstration programs. In Rhode Island, because of the state's mainstreaming clause, all physicians participating in commercial MCOs were required to serve RIte Care patients.[20] In Tennessee, Blue Cross/Blue Shield (which had the "cram-down" provision) also relied on its extensive set of participating providers. Even

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"However, one plan acknowledged that 11 percent of its panel of primary care physicians would not take RIte Care.

in these situations, however, there were some modifications to accommodate clients and providers in certain areas. For example, in each state, HCFA required that MCOs contract with FQHCs unless they could demonstrate an adequate capacity to serve the low-income populations without them; therefore, MCOs often developed new contracts with community health centers.

Usually MCOs needed to recruit a network of providers quickly to serve the demonstration populations; therefore, they were not particularly exclusive in recruiting providers. Across the three states, physicians who wanted to participate in MCOs were rarely rejected, and most hospitals signed contracts with a number of MCOs. On the other hand, providers often were selective in determining their affiliations: sometimes they preferred particular MCOs (for example, community health centers preferred to contract with the FQHC-related MCOs) or wanted to affiliate with only one or two plans to reduce administrative burdens.

Newly developed or rapidly expanding MCOs required special recruitment patterns. The FQHC-related MCOs in Hawaii and Rhode Island used the health centers as the core of primary care providers. The Rhode Island MCOs identified specialists who already worked with the FQHCs, while Hawaii drew from the University of Hawaii medical faculty for specialists. Access MedPlus (which grew tenfold with the start of TennCare) used its existing network of physicians to help recruit others, especially in other parts of the state.

Since Hawaii permitted QUEST-only networks of physicians, provider availability could have been a more serious issue there than in the two other states. Analyses of provider lists (see Chapter IV) suggest that there were a sufficient number of physicians statewide, although there may have been shortages in the rural area we visited. We also heard that access was more difficult in some areas in Tennessee and Rhode Island. Of course, it seems likely that access was also a problem in some areas under fee-for-service Medicaid.

In Tennessee and Hawaii, MCO contract negotiation was new to many providers, especially physicians. Physicians in these states often felt they had almost no bargaining power in negotiations. Physicians were often offered options about payment mechanisms (for example, discounted fee-for-service versus capitation) or the number of patients they would accept; however, the payment levels and contract terms were viewed as nonnegotiable. In some instances, physicians (particularly specialists) grouped together in opposing the new managed care plans. This strategy led to apparent shortages of some specialty areas in TennCare and QUEST. In contrast, hospitals seemed to have somewhat more bargaining power than physicians and were sometimes able to negotiate more favorable terms with MCOs.

2. Physicians

Although a general goal of each demonstration program was to shift from fee-for-service to capitated care, physicians were still usually paid by the MCOs on a discounted fee-for-service basis, not capitation. This varied somewhat from plan to plan and depended on the practice sites of physicians. For example, FQHCs or group practices were more likely to be capitated than solo physicians. Specialists were usually paid on a fee-for-service basis. Even where physicians were paid on a fee-for-service basis, sometimes there were managed care adaptations (such as case management fees or performance-related withholds or bonuses). Use of capitation may rise over time as physicians become more comfortable with the new MCO relationships. In the first year of the demonstration projects, physicians bore relatively little risk in the new managed care arrangements.

Physician reactions to the demonstrations varied from generally satisfied with RIte Care (about payment levels, although not administrative aspects), to somewhat dissatisfied with QUEST, to more opposed to TennCare. At the very beginning, physicians' attitudes were affected by the extent to which the states conferred with them during the design process. The most widely publicized physician opposition occurred in Tennessee, where physicians felt excluded from the demonstration implementation process. The Blue Cross/Blue Shield "cram-down" provision and seemingly low payment rates further antagonized

physicians. Physicians in Hawaii were also upset by the lack of public debate regarding the demonstration; however, the QUEST payment rates were similar to predemonstration levels, so this was less of an issue. In comparison, Rhode Island physicians seemed more supportive of RIte Care. State officials had consulted with the medical society before implementation, and an explicit goal of the program was to increase payment levels for primary care physicians.

After the demonstrations began, physicians' complaints centered around implementation snafus, such as significant delays and mix-ups in patient assignment to primary care physicians, confusion over eligibility status, and problems handling referrals. One troublesome problem was the disruption of long-standing physician-patient relationships. Physicians reported that, despite patients' requests, the enrollment systems often assigned their patients to other doctors. Physicians and consumers in TennCare and QUEST experienced more such disruptions than did those in RIte Care, perhaps because of the speed of implementation and other factors. These complaints became less frequent as the states and MCOs worked to correct implementation problems. In Tennessee, another snafu was payment delays and high rates of claims denials, caused largely by inadequate claims-processing systems in some MCOs.

On a longer-term basis, physicians cited two persistent issues (often voiced as complaints about managed care in general). The first, mentioned in Tennessee and Hawaii, was the added administrative burden arising from managed care practices. Many physicians stated that managed care required more staff effort (such as referrals or preauthorization requests), but physician payments were not always augmented to account for the additional efforts. These burdens were compounded by the fact that different MCOs had different administrative requirements, which increased confusion. In Rhode Island, physicians already had relationships with the MCOs, so they understood the MCOs' requirements. A second issue, voiced in all three states, was the lack of patient education about managed care principles by either the state or the MCOs. As a consequence, enrollees often self-referred themselves to specialists or emergency

rooms, and the burden of explaining the new managed care rules fell upon the physicians and their staff members.

3. Hospitals

One interesting element of the demonstrations was that they provided an opportunity for some hospitals to develop vertically integrated MCOs, consolidating the insurance function with hospital care and physicians into a single plan. These included Vanderbilt Health Plan, Total Health Plus, and TLC in Tennessee and Straub in Hawaii, each related to major hospitals in the states. In general, hospitals were paid using negotiated per diems or Diagnosis Related Group-related payments; capitation was uncommon. However, as noted earlier, there were some vertically integrated plans that gave some hospitals more of a financial stake in the programs.

Hospitals' perspectives on the demonstrations varied across the three states. Hospital associations and hospitals in Hawaii and Rhode Island had a "wait and see" attitude; they felt it was too early to assess the impact of the new programs. Although both states hoped to use managed care to reduce hospitalization, the results were not apparent when we visited.

In contrast, some Tennessee hospitals had serious problems with TennCare or specific MCOs. Hospitals found that some MCOs paid less than the prior Medicaid payment rates (particularly if disproportionate-share hospital payments were included), and some MCOs were paying very slowly (creating major cash flow problems). One widely publicized example of a public hospital experiencing serious financial hardship is the Regional Medical Center (The Med) in Memphis. The Med lost various public subsidies (such as disproportionate-share hospital funds and other state funds) and was experiencing other problems in the transition to managed care. Because of budget problems, The Med has sharply downsized and closed certain units, In comparison, Le Bonheur Children's Hospital in Memphis had difficulties in the first year, but was able to leverage improved payments after it threatened to stop participating unless plans upgraded their processing and improved payment rates.

4. Community Health Centers and Public Health Departments

FQHCs and public health departments, traditional providers of care to needy populations, were particularly concerned about the shift to managed care. State primary care associations were among the most vocal critics of the Section 1115 demonstration programs. Health centers feared that they would lose their cost-reimbursement status and suffer lower payment rates and that some of their patients would migrate to commercial MCOs or physicians.[21] Furthermore, health centers worried that managed care systems did not accommodate enabling services (such as social services or language translation) that were as important as medical services in serving many low-income or uninsured individuals.

In Rhode Island and Hawaii, FQHCs banded together and started their own MCOs (Neighborhood Health Plan of Rhode Island [NHP-RI] and AlohaCare, respectively) to help ensure that centers received better payments as providers. In addition, they sought supplemental support from the state to bring them close to cost-reimbursement, at least on a transitional basis. Rhode Island agreed to pay an extra $10 per month for enrollees selecting FQHCs as primary care providers. However, Rhode Island health centers continued to experience problems because of reductions in caseload, perhaps partly caused by the delay in licensing NHP-RI. Hawaii was negotiating an additional lump sum payment to aid FQHCs that were particularly affected by the loss of cost-reimbursement. There were no special accommodations for FQHCs in Tennessee; their financial status under TennCare appeared to vary across the state.

The coordination of public health services and managed care has sometimes been difficult. The demonstrations have altered funding streams, so that state and county health departments are often getting less funding from Medicaid than before. Moreover, the demonstrations have altered the role of safety net providers, as they struggle to identify the boundaries between their responsibilities and those of MCOs.

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[21] HCFA waived standard Medicaid requirements that FQHCs be paid based on the actual costs of care, which typically increases payment rates substantially.

H. CONSUMER AND ADVOCACY VIEWS

In focus groups, consumers were generally satisfied with their medical care, although the chronically ill or disabled were less satisfied. Consumers often encountered problems or confusion while enrolling in the program or selecting MCOs or physicians.

To understand the program from the consumers' perspectives, we held focus groups in each state and met with consumer advocates.

1. Focus Groups

In each state, we convened three consumer focus groups: (1) an urban low-income group, (2) a rural low-income group, and (3) a disabled or chronically ill group. Because the respondents were not randomly selected and the samples were small, the responses should not be viewed as statistically representative of the demonstration populations. However, they provide useful insights into the reactions of a handful of consumers. Certain themes often arose:

- Low-income consumers were typically satisfied with their primary care providers and the medical care they received. Sometimes they were frustrated with delays in getting appointments or referrals, but this may also have been a problem under fee-for-service Medicaid.
- Chronically ill and disabled consumers were somewhat less satisfied with their medical care. They had greater concerns about reduced access to specialists and emergency care.
- Administrative problems, such as diffkulties in or confusion about enrollment or selection of an MCO or primary care provider, were relatively common. In addition, respondents often found that program staff members were not sure of the rules either.
- Relatively little patient education about how to select an MCO or about managed care was provided in Tennessee and Hawaii.
- Delays in getting MCO membership cards were common, leading to difficulties in getting care in the "gap" period.
- Consumers often switched to new physicians when joining an MCO (sometimes voluntarily, sometimes not). Although enrollees typically tried to select a plan that had their doctors, sometimes their doctor did not participate in any MCO or there was a conflict with MCOs that had other family members' doctors. Sometimes enrollees had a hard time learning which doctors were in which plans.

- Respondents sometimes were also concerned about access to, or switching of, other providers, including dentists, hospitals, and pharmacies.

Some of the difficulties, such as confusion at the beginning, may be transitory and could become less acute over time as people become more familiar with the new system. Other problems, such as switching doctors or chronically ill/disabled clients' concerns, are at least partially inherent in managed care. Because MCOs may try to save money by restricting the set of participating providers or reducing apparently unnecessary care, patients will have some limits on their flexibility. It is difficult to say whether these limits also compromise the quality of medical care provided. We heard a few reports that suggested delays in getting appropriate care or barriers that led patients to seek out-of-plan care that they paid for out of their own pockets.

Involuntary or accidental doctor switching appeared to be more of a problem in Hawaii and Tennessee than in Rhode Island. At least part of the problem appeared to be that lists of physicians participating in each MCO were not always readily available to clients at the time they made their MCO selection or that some participating doctors were no longer accepting new Medicaid patients at that time. In those two states, respondents also reported that it was sometimes difficult to change primary care providers within a given MCO. In Rhode Island, consumers appeared to feel that managed care improved access to physicians. A few in Rhode Island also mentioned voluntarily leaving community health centers to be seen by private physicians.

2. Consumer Advocates

The roles of the advocacy community varied considerably among the states. In Tennessee, some advocates were involved with the planning and design of TennCare. By contrast, in Hawaii and Rhode Island, advocates had little involvement prior to implementation of the program. In Rhode Island, the legal aid society was very concerned in the beginning and considered suing the state.

After implementation, advocates generally became more involved, often as members of policy advisory groups (which also include provider representatives). Advocates in all states expressed concerns about barriers for special populations (such as cognitively impaired children or pregnant women) or for certain health care providers (such as community health centers or public hospitals). Sometimes the advocates were able to work with the state or the MCOs to modify policies. For example, in Hawaii, a special unit was set up to expedite eligibility processing of pregnant women and in Tennessee, an advocacy hotline was established to help enrollees with TennCare concerns.

I. CHANGES AFTER THE FIRST YEAR

Although the basic program structures have been retained, policies andprocesses continue to be refined as time passes.

All three initiatives have survived substantial changes in state political landscapes after the first year. Democratic governors started RIte Care and TennCare in 1994, but Republican governors succeeded them in 1995. Hawaii changed from one Democratic governor in 1994 to another in 1995. Although each demonstration had some controversy during its first year and encountered some political opposition, the new governors all supported and maintained the demonstration programs.

While the basic structure of each initiative remained the same after the first year, the reform efforts witnessed incremental changes in policies or procedures, Each state also evolved in its process of decision making. The demonstration programs were typically developed or implemented in haste and with little involvement of stakeholders. After implementation, however, states developed special advisory committees or other forums for policy discussions among the state, consumers, providers, and other stakeholders. HCFA is now requiring states applying for Section 1115 demonstrations to include a public comment period.

In these three states, as in all states in the nation, the uncertainty about future federal Medicaid policy and budgets has made long-term planning difficult. At the time of our site visits, states were aware of

discussions to block grant Medicaid and cap spending, but were unsure how this would affect them. At the time of this writing, future federal Medicaid policy is still uncertain because of continuing budget disagreements between Congress and the President. Our impression was that, if Medicaid funding is reduced (relative to their budget neutrality agreements), the states would continue to require managed care. They would like to maintain at least some of the expansions permitted by the Medicaid waivers but would need to consider changes in eligibility or covered services to stay within tighter budgets.

a. Policy Changes

Tennessee and Hawaii both encountered budget problems in their first year and undertook program retrenchment. At the end of 1994, Tennessee stopped enrolling new uninsured clients (except fop people losing Medicaid eligibility). At the end of 1995, the state was planning to increase premium levels in the hope of increasing patient revenue and constraining participation. Hawaii also increased premiums so that they began at 100 percent of poverty, rather than 13 3 percent. QUEST eligibility rules regarding students and the self-employed were also tightened. In April 1996, Hawaii undertook a major reduction in the scope of QUEST. In contrast, Rhode Island had fewer expansion clients than anticipated and extended the age limit for expansion children from age 6 to age 8.

Planned extensions of QUEST and TennCare were delayed, by the state (Hawaii) and HCFA (Tennessee). Hawaii planned to add the disabled into QUEST as well. Tennessee planned to develop managed care plans for the severely and persistently mentally ill and emotionally disturbed children. Tennessee implemented the severely and persistently mentally ill plan in 1996, while the other expansions for TennCare and QUEST appear to be on hold at this time.

b. Procedural Changes

States and MCOs were aware of administrative problems, such as enrollment delays or confusion about policies. Some of these problems became less acute as the initial rush of startup concluded, and

everyone became more familiar with the programs. Beyond this, each state appeared to be making serious efforts to solve problems such as enrollment delays.

Two program elements that were scheduled to become more prominent in the second year were quality assurance/quality improvement and data systems. Developing actual quality measurement systems or standards and developing encounter data systems requires detailed negotiations and systems testing that can only occur after MCOs are in place. In some cases, these efforts also require new contracts (such as those for data processing firms or for organizations to conduct consumer satisfaction surveys). At this time, we are unable to assess the quality of care being provided by the MCOs or the quality of the encounter data being submitted.

J. LESSONS LEARNED

This final section offers some preliminary thoughts aimed toward those who are considering implementing large-scale Medicaid changes like those discussed in this report. Because this is the first-year report from a broader 5-year study and is primarily based on qualitative information, we do not have rigorous assessments of program impacts, nor can we be certain that the issues observed in these three states would necessarily apply to other states. Acknowledging these uncertainties, we believe that important lessons are:

1. ***States can implement major changes in a short period.*** The three states implemented major demonstration projects in a short time period. These major achievements involved the combined efforts of state and federal agencies, MCOs, health care providers, and advocates. To varying degrees, each state provide health care coverage to new groups that would have otherwise been uninsured.

2. ***States should allow enough time for planning and implementation.*** Tennessee's schedule was too tight, and a wide array of problems occurred because of inadequate planning and communication. Both Hawaii and Rhode Island took about 1 year to implement and still encountered difficulties. The level of chaos and confusion is exacerbated when implementation occurs statewide all on one day. Although Rhode Island's rolling implementation schedule also had shortcomings, it did not tax the capacity of the system all at one time. The director of Arizona's long-running demonstration program has recently stressed the need for adequate planning time (Chen 1996).

3. ***Despite their start-up problems, the demonstration programs survived major state political changes.*** Once programs such as these are under way, it is difficult to drop them. Each state elected a new governor, and two states elected a governor from a different political party. Despite controversy, the new administrations continued to support the demonstrations and, in some cases, made important program improvements.

4. ***Newprograms need to have enough administrative resources.*** At least in the short term, states may require more administrative capacity, particularly if they are continuing to use fee-for-service for some populations or services. Each state ran into shortages of staff, especially enrollment or consumer relations staff, at the beginning. States constructively used private consultants to help design and/or manage elements of their program (especially new managed care contracting and capitation rates) and added expertise that was not otherwise available among state staff From the start, the state needs to develop adequate automated data systems that are suited to enrollment and payment functions for managed care programs; standard MMIS and related eligibility systems were not designed for these purposes. States may have underestimated the resources needed to monitor MCOs. In states with little managed care experience, MCO start-up problems can be serious and can have long-lasting consequences. Rhode Island, which had the strongest managed care market and the best developed HMO licensure requirements, had fewer problems than Tennessee.

5. ***Clients and health care providers want more patient education about managed care.*** A common complaint made by both clients and medical staff was that enrollees did not understand their choices among MCOs or how managed care worked. Only Rhode Island made any serious attempt at patient education, but providers felt that even more education was needed. This is most important when the program is new, and there is not much word-of-mouth advice available within the community. At the minimum, states should have up-to-date directories of participating physicians available for clients to help them select MCOs when they enroll. Ongoing education can be used to explain topics such as how to use primary care gatekeepers and when to use the emergency room.

6. ***States need to pay careful attention to enrolling pregnant women and newborns.*** Each state encountered snags in enrolling one or both of these groups. States need to develop a simple method to ensure that a newborn is enrolled and is assigned to the MCO in which the mother participates, This process would improve continuity of care and give the MCO a greater incentive to ensure that high quality prenatal care is given. For pregnant women, the state needs to ensure an expedited eligibility process, since application backlogs often occur at the start of a program.

7. ***Unanticipated budget problems can undermine expansions.*** Each state suffered unanticipated budget problems. Tennessee was unable to raise enough funds for the state share and was forced to curtail enrollment of the uninsured late in its first year and make a number of budget adjustments in the first and second year. Hawaii's participation levels and capitation rates were much higher than expected, forcing program cutbacks in 1995 and 1996. Rhode Island seriously overestimated the number of expansion women and children that would be served; they have since increased eligibility for children.

8. ***Medicaid managed care can be expanded rapidly, although it is too early to assess the quality of care or the MCOs' long-term financial stability.*** An initial question was whether MCOs would bid or would be formed to handle massive expansions of managed care, especially since these states had limited Medicaid managed care experience. Each state was able to encourage a number of plans to participate, and some new MCOs were developed explicitly for the programs.[22] Some of the new MCOs could not have been formed under standard federal rules, such as FQHC-related or Medicaid-only plans, Generally, the MCOs that expanded to serve the most patients used network-style managed care (that is, IPAs or PPOs), as opposed to group-model HMOs. Networks could be formed in rural areas, as well as in urban ones. Even so, there were access problems for some areas or physician specialties. In most cases, physicians continued to be paid on a discounted fee-for-service basis; physician capitation was not the norm. Although MCOs were formed successfully, it is difficult to assess the quality of care provided by the plans, and it is too early to assess the financial stability of the plans (especially new plans or those that expanded rapidly). The stronger commercial managed care markets in Hawaii and Rhode Island, and Rhode Island's strong licensure requirements, appear to have improved the transition to managed care in these states, compared with the process in Tennessee. The lack of experienced MCOs in Tennessee led to problems, suggesting that states need to review MCO readiness more carefully and limit the size of enrollment in some MCOs, such as newer ones, until these MCOs have proved their ability to operate smoothly. Monitoring quality and financial stability will be important in future years,

9. ***Safety net providers require special support.*** The experience of safety net hospitals in Tennessee suggests that states or MCOs may need to make special arrangements for these providers to ensure that they can make a transition to managed care and continue their mission to provide care to vulnerable populations. In all three states, some FQHCs experienced problems, partly caused by the loss of cost reimbursement. Rhode Island and Hawaii provided some supplemental payments to assist FQHCs.

10. ***It is not clear whether competitive bidding or rate setting leads to better or more stable rates.*** Most economic theory suggests that competitive bidding leads to the lowest and most efficient rates. Although it is difficult to compare the capitation rates in each state because of structural differences, it appeared that Tennessee's rates (which were set administratively) were the lowest. Even in Hawaii and Rhode Island, where competitive bidding occurred, the initial bids were followed by administrative negotiations to lower the prices. It is possible that states' rates will converge over time: Hawaii was able to reduce capitation rates slightly between Years 1 and 2, while Tennessee has increased rates faster than planned. In the long run, the MCO capitation rates offered (whether through competition or rate setting) must be reasonable by market standards to continue to attract participation by enough MCOs and health care providers. If the capitation rates drop too low, it seems likely that some MCOs and providers will cease participation. This would reduce the possible competitive field and push rates up again.

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[22] The expansion of Medicaid managed care over a short period was also feasible in Arizona and Oregon, However, recent problems in attracting MCOs for Vermont's Section 1115 demonstration show that developing contracts with enough MCOs may not always be feasible.

11. ***Flexibility and communications are important; conditions can improve over time.*** Each state's startup began with a period of upheaval, chaos, and controversy. Our impression is that conditions were more stable and less controversial by the end of the first year. An important key in each state was the ability of the state, the MCOs, health care providers, and other stakeholders to keep lines of communication open and to be flexible in approaches to problem solving after the programs began.

Given the scope of changes and the limited time frames in which these programs were undertaken, the implementation of these demonstration programs is a major achievement that involved combined efforts of state and federal agencies, MCOs, health care providers, and advocates. In varying degrees, each state provided health insurance to new groups that would otherwise have been uninsured. Continuing assessment of these and other Section 1115 demonstration projects should help us understand the feasibility and implications of state health reforms involving the Medicaid program.

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APPENDIX A

PHYSICIAN FOCUS GROUP FOR RITE CARE

A focus group of RIte Care primary care physicians was conducted to gain a perspective on physicians' reactions to RIte Care. A range of topics related to RIte Care and managed care was discussed, including the physician/managed care organization (MCO) relationship, physician payment levels, changes in patient caseloads, patient understanding of RIte Care and managed care, quality of care, and referral networks under RIte Care.

FOCUS GROUP COMPOSITION

Three MCOs (HMO Rhode Island, Pilgrim, and United) were asked to identify obstetricians, pediatricians, and other primary care physicians in the Providence area for the focus group.' In addition, RIte Care officials provided a complete listing of primary care physicians participating in RIte Care. The final selection process tried to ensure that an equal number of physicians were invited from each plan and that the focus group include a range of primary care physicians (including pediatricians and obstetricians, as well as internists and general practitioners). Physicians actively involved in planning or advising about RIte Care were not to be nominated, because the discussion was intended to be representative of regular, practicing physicians. All respondents received dinner and $100 for participating; only Mathematica Policy Research, Inc. and Urban Institute researchers and the physicians were present at the meeting.

Ten physicians (of the 15 recruited) participated in the focus group, which was held in Providence in August 1995. Of the attendees, three were internists, three were obstetricians/gynecologists, three were pediatricians, and one was a general practitioner. Five of the physicians had solo office-based practices, two had small group practices, and two worked at

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'We did not invite participation from the Neighborhood Health Plan or Harvard Community Health Plan, since their primary care physicians are primarily salaried doctors. However, a number of physicians who participate in these plans also participate in other plans and therefore attended the focus group.

community health centers. One had a hospital, academic, research, and administrative practice. Three reported having obtained their medical degrees in the past 10 years and four prior to 1985; one did not respond.

OVERALL PERCEPTIONS OF RITE CARE

Following are the main perceptions of RIte Care that physicians in the focus groups had:

- They received significantly higher payments under RIte Care than under fee-for-service Medicaid, and they received these payments in a much more timely fashion under RIte Care.
- They faced more paperwork burden under RIte Care than for their commercial patients in the same plans.
- There was inadequate orientation for enrollees about managed care and the gatekeeper model; thus, providers felt they were required to provide this education themselves.
- The MCOs were overmanaging them.
- They were concerned about the suitability of providing care to traditional welfare and Medicaid recipients in private physician's offices, because these offices lack the needed enhanced services many of these patients require.

COMPARISON OF RITE CARE AND MEDICAID

Prior to RIte Care, all except two of the focus group physicians accepted Medicaid patients. Of the eight physicians who participated in Medicaid prior to RIte Care, however, three limited their participation to individuals who were patients prior to becoming Medicaid eligible or who had special circumstances Currently, all physicians serve RIte Care patients. The RIte Care patients as a percentage of their total patients varied considerably among the physicians. In addition, the physicians claimed that the RIte Care program did not noticeably affect overall patient caseloads.

Physicians reported that the transition to RIte Care caused much disruption of old patterns of care. This was particularly true of emergency services. In general, when a patient goes to the emergency room, the managed care desk or admitting clerk calls the patient's physician and asks for authorization to treat

the patient. If the physician does not approve the care, the patient will be turned away. There were mixed reports as to how physicians felt about this. Some felt the system would encourage more appropriate care in the long run. "I actually had somebody who walked into the ER about six o'clock, or five o'clock at night, and needed stitches taken out and I said, 'No, I'm still in the office, send him here,' and I sort of felt like that's the way [the] system is supposed to work. It's supposed to keep the silliness out of the ER." Sometimes, however, the patients were individuals the physician had never seen. "Oftentimes I'get a call from the emergency room. . . A patient is there, I'm her primary care provider because she signed up with me, I've never see[n] the patient. But she's there in the ER and they, the ER, need my permission to treat her. What am I going to say, 'No' ?" Others were reluctant to make a decision over the phone not to treat someone already at the hospital without an examination for liability reasons. They were concerned that, if a bad outcome were to occur, the physician (not the MCO) would be liable; therefore, they tended to approve emergency room care.

Two major concerns with the move to RIte Care were the lack of consumer education about managed care and the movement of the site of care from community and hospital clinics to private physician offices. In general, the physicians were frustrated by the lack of education provided by the state for RIte Care enrollees. For example: "And I don't know who is talking to them when they call and sign up for these plans, but we have to start all over from scratch. It's an incredible amount of time that our nursing staff and our administrative staff and our financial consultant staff have to do with every single patient that comes in. They don't have a clue about the managed care system. They don't understand what they need for prior approval. They don't understand who their primary provider is. They don't understand Medical home. They don't get any of it."

Respondents noted that RIte Care has a large population of non-English-speaking enrollees and individuals with low educational attainment. They stated that the movement to managed care was very confusing to many RIte Care enrollees who did not understand that they could no longer go to the

emergency room, that they had a primary care gatekeeper who had to approve all referrals, and that their choices of providers were limited. This created difficulties for the patients and administrative hassles for the physicians: "I see some of them and they'll call me up [and say]. . . . 'I went to this gynecologist and he wants me to see XXXX doctor.' I had one of these patients who went to see three and I didn't even see the lady. I said, 'I'm not [sending you to] this guy, this guy, that guy, because the other one said so. If you want to get another primary care physician [go ahead], I'm not just a throughway'."

Equally important, a number of physicians (principally two who practice in community health center and hospital clinics, but also some private-practice physicians) raised serious concerns that the shift in the site of care from hospital outpatient clinics and community health centers to private physician practices may result in less appropriate services for non-English-speaking enrollees and enrollees with complex psychosocial problems (such as low educational attainment or substance abuse problems) because private practices do not have the resources to meet the needs of these types of patients. "I mean, the violence and the incest and I mean, it's just incredible. And so if one of our patients picks a private physician who's not used to seeing this, and doesn't have the support service, I mean we've got nutritional staff, we've got social workers, we've got all this other stuff, we have special projects of people, who are substance abusing, and ten percent of pregnant women in the state test positive for illicit drugs. They walk in one of these private doctor's offices--where. is this person supposed to come up with all these support services?--and yet they're required to provide them if they're going to be a RIte Care provider." These physicians further argued that community health centers and hospital outpatient departments remain the most appropriate settings in which to provide care to the Medicaid population with medical and nonmedical needs; this is because of the additional time built into appointment slots and the presence of bilingual staff members and psychosocial support services on site. These physicians expressed deep concern about the content of the care that these patients would receive from private-practice physicians.

In contrast, most physicians agreed that, for those RIte Care enrollees who had higher incomes and lived in more suburban areas (the working poor) RIte care was probably an improvement over being uninsured or being on Medicaid. They also felt that this population of RIte Care enrollees was probably adequately and appropriately served by private physicians under RIte Care.

SELECTION OF MANAGED CARE PLANS UNDER RITE CARE

Unlike in other states with Section 1115 waivers, all physicians participating in RIte Care MCOs are required to serve RIte Care patients, as a result of RIte Care's mainstreaming provisions. Therefore, the decision about whether or not to serve RIte Care patients is different for Rhode Island physicians. Among the focus group physicians, eight served RIte Care patients under United, seven under Pilgrim, seven under Health Maintenance Organization--Rhode Island, three under Neighborhood Health Plan--Rhode Island, and one under Harvard Community Health Plan. All of the respondents participated in more than one plan. Five participated in three plans, one in two plans, one in four plans, and one in five plans.

PAYMENT ISSUES

Physicians reported that payment levels under RIte Care are higher than under fee-for-service Medicaid. "And then RIte Care came along and so most people, at least the pediatricians I talked to, were very happy just because anything was better than the present system. But it still isn't great, . . and RIte Care is an improvement, but it's still substantially discounted on what you get from just everybody else, and it's not as if the patients themselves are much lower maintenance. The patients usually require quite a bit more, because, unfortunately, they're needier in other ways." The physicians also felt they received payments more quickly under RIte Care than under fee-for-service Medicaid. Most of the respondents were being reimbursed on a fee-for-service basis. At the same time, the physicians noted that in all but one of the plans (Pilgrim), they are paid at rates that are lower than those of their commercial patients. Moreover, within the RIte Care program, they are paid different rates to provide the same services,

depending on the MCO. This has led some of them to encourage their patients to enroll in Pilgrim; however, Pilgrim has significantly limited RIte Care enrollment.

OTHER MANAGEMENT ISSUES

Two separate, but perhaps related, management issues were brought up in the focus group. The first had to do with referrals. While all of the physicians had participated with the MCOs prior to RIte Care, many of the managed care products they were involved with were not gatekeeper models. While they were familiar with managed care, they were less familiar with the referral process and felt that the paperwork was burdensome.

The second issue had to do with prescription drugs. Under RIte Care, many pharmacies will not allow physicians to call in a prescription over the telephone. The patient has to bring the actual prescription in, or (in some cases) a pharmacy will allow the physician to mail in the prescription the next morning. They were further frustrated because pharmacies will accept telephone prescriptions for commercial patients using the same MCOs. In addition, a number of physicians noted that they had problems obtaining authorization to prescribe certain drugs. While authorization to prescribe certain drugs can be obtained, the authorization process can consume a significant amount of office staff hours, A physician related this story about a woman whose medicine was not on the formulary list: "I contacted my business manager, who called an 800 number to get approval. You go through an automated system which goes through number one through seven. We, unfortunately, had to wait for seven. And when we got that, they then told us we had to call a national 800 number. So we had to start all over again and go through another automated system. That person gave us an authorization after I told them that there was no alternative. . . gave us an authorization which we had to write on the prescription pad; we had to call the pharmacy and give them the authorization, the patient had to come back in to pick up the written prescription, and take it back to the pharmacy. She made. . four trips unnecessarily. She ended up getting the [same] medicine that we wrote for her initially, and we have had that; that's not an isolated incident. We had people who

we had written penicillin for strep throats and they go, we called in the prescription, they will not fill it over the phone."

In general, physicians felt that MCOs were forced either to develop heavy-handed management styles for both patients and physicians under RIte Care or to face financial losses on the RIte Care program. "So if I'm the chairman of United Health Plan, and I agree to take on X percentage of the RIte Care population my goal is to manage that population, knowing that they're going to be tough as nails to keep a handle on. So I'm going to really overapply managed care principles and try to control costs. So I'm going to set up the managed care desk at Hasbro [the Children's Hospital in Providence]. . and everybody that walks in is going to walk right out. You've got to be horizontal to get into my emergency room. And that's so. . It drives physicians nuts because you don't want to be in countermanaging your patients, for whatever reason, whether or not I'm more expensive than the next guy. . . So as physicians it's very, very odious to kind of deal with that stuff, but at the same time from the financial guy's perspective, I see what they're doing. They're trying to really heavy-handedly apply managed care principles to a very tough system, and you can only hope that over time it would shake out to something that's a little more palatable." The focus group physicians felt very strongly that both physicians and enrollees were being overmanaged. They resented administrators dictating the types of drugs they could prescribe and some of the authorization requirements (for example, for referrals for routine gynecological examinations or for existing relationships with specialists who manage chronic-care needs).

PATIENT RELATIONS

As mentioned previously, physicians felt very strongly that the state did not provide enough education about managed care. They felt that this placed a considerable burden on providers, especially for primary care providers who had to both attempt to provide education and deal with the consequences of this lack of understanding. At the same time, some felt that the behavior of some enrollees should change. Other

respondents noted that the move to managed care is a significant change for this population, and that it should have moved more slowly, with more appropriate and thorough education efforts.

In addition, some physicians noted that, with the move to RIte Care, they became primary care physicians for patients with chronic problems whose care had been previously managed by specialists. For the patients to continue with their existing providers, they had to first be seen by their primary care physician and then be referred to a specialist. Physicians noted that this was quite frustrating for the patients.

QUALITY OF CARE

As mentioned previously, there were mixed opinions about whether the quality of care was improved for RIte Care enrollees. Most respondents felt that, for the working poor (who previously might have been uninsured or on Medicaid) access and (potentially) the quality of care are probably greater under RIte Care. However, for those individuals who have traditionally been Medicaid eligible and are being served in private physician practices, the content of care and (potentially) the quality of care are probably reduced under RIte Care.

APPENDIX B

CONSUMER VIEWS IN RHODE ISLAND

Three focus groups were held in Providence and Wakefield in August 1995 to solicit consumer input on RIte Care. Two locations were used, so that low-income people in both urban and nonurban settings could participate. The third group, which also took place in Providence, was made up of people with chronic health needs. There were problems with recruiting participants for all three focus groups, so that attendance was lower than expected. Nevertheless, the groups provided some insights about the conversion to RIte Care, as well as consumer knowledge and attitudes toward managed care. These focus groups, however, were not intended to be a statistically representative sample of RIte Care enrollees or the uninsured population in Rhode Island.

COMPOSITION OF CONSUMER FOCUS GROUPS

The Rhode Island Office of Managed Care chose to take responsibility for the recruitment of focus group participants, following protocols provided by the evaluation team. Participants were promised confidentiality, and $25 was offered to cover expenses for attendance. For a variety of reasons, however, this recruitment was not very successful. In total, 14 people attended the meetings: 9 in the urban low-income group, 3 in the nonurban low-income group, and 2 in the chronically ill group. We were not able to obtain precise numbers on those who agreed to come but did not show up.

The 14 participants included 12 adults who were current RIte Care enrollees and 1 mother of children enrolled in RIte Care. The remaining respondent was the mother of a deceased chronically ill child who used to be on Medicaid. All the respondents, except one, were female. Table B. 1 shows other descriptive data.' Most respondents had income well below the poverty level. The families of 8 of the 14 respondents were receiving some form of cash assistance (3 families received both Aid to Families with Dependent Children and Supplemental Security Income). Three of the 14 respondents had part-time jobs, while 1 was fully employed.

'Tabular data in this chapter are based on responses to a short questionnaire administered before the discussions began. Thus, they should be unaffected by any opinions expressed during the discussions.

TABLE B. 1

SELECTED CHARACTERISTICS OF CONSUMER FOCUS GROUP MEMBERS

Trait	Number
Race/Ethnicity	
Hispanic or Latino	1
Black or African American	5
White or Caucasian (not Hispanic)	7
American Indian/Native American	1
Receipt of Public Assistance	
AFDC	7
General Assistance	1
SSI	3
Prior Receipt of Medicaid	10
Family/Household Size	
One	1
Two	--
Three	5
Four	3
Five	2
Six or more	2
Income Level Last Month	
Less than $1,000	9
$1,000-2,000	2
Not ascertained	3
Work Status	
Part-time job	3
Full-time job	1

AFDC = Aid to Families with Dependent Children; SSI = Supplemental Security Income.

For the most part, the respondents and the family members with whom they lived were all enrolled in RIte Care or Medicaid and had no additional health insurance. There was one teenage mother who lived with her parents, who had private insurance; she was covered under their insurance plan, in addition to her RIte Care coverage. One disabled mother was a Medicare beneficiary (in addition to being on Medicaid), and one household included an uninsured adult male.

Serious medical problems that respondents reported for their family members included major depression, cerebral palsy, asthma, diabetes, and attention deficit disorder. The chronically ill group also included the mother of a child, recently deceased, who had had severe neurological, respiratory, and seizure disorder problems. Of the respondents, however, only two group members reported any serious disabilities or medical problems. One respondent was a disabled mother with chronic fatigue and immune disorder syndrome, while the other one had major depression. During the discussions, the other respondents mentioned more routine health care problems and needs (such as pregnancy-related services, care for kidney stones, dental care, knee and back problems, broken bones, and eye infections).

Only three of the five managed care organizations (MCOs) were represented among the respondent group (see Table B.2). There were no participants from the Harvard Community Health Plan or Pilgrim Health Care, both of which have relatively small enrollments. Compared with overall enrollment patterns, representation of Health Maintenance Organization-Rhode Island members was higher than expected, while Neighborhood Health Plan-Rhode Island was lower than expected.

OVERVIEW OF CONSUMERS' CONCERNS

Most members of the urban and nonurban low-income focus groups were satisfied with their new arrangements under RIte Care. Table B.3 summarizes responses to two questions about satisfaction with their MCOs and the physicians or nurses seen while on RIte Care. The focus group respondents did have complaints, but they primarily related to general managed care procedures and the RIte Care enrollment process and verification system, instead of to individual plans or physicians.

TABLE B.2

MEMBERSHIP OF RESPONDENTS AND OTHER FAMILY MEMBERS IN RITE CARE MCOs

Managed Care Organization (MCO)	Number of Respondents in MCO	Total Number of Other Household Members in MCO
HCHP (Harvard)	0	0
HMO-RI (Blue Cross/Blue Shield)	3	7
NHP-RI (Neighborhood)	2	6
Pilgrim	0	0
United	6	10

TABLE B.3

GENERAL SATISFACTION WITH MEDICAL PLANS
AND PHYSICIANS IN RITE CARE

Questions	Urban and Nonurban Low-Income Groups
Overall, how satisfied have you been with the health plan that you used while you were on RIte Care?	
Very satisfied	6
Somewhat satisfied	3
Somewhat dissatisfied	0
Very dissatisfied	0
No opinion	3
Overall, how satisfied are you with the physicians or nurses that you have seen while you were on RIte Care?	
Very satisfied	7
Somewhat satisfied	1
Somewhat dissatisfied	0
Very dissatisfied	0
No opinion	1
I haven't seen a physician or nurse yet	3

Many respondents mentioned the stigma associated with Medicaid and welfare. They felt that the new RIte Care system was a move toward mainstreaming the low-income population into the regular health care system, where they hoped there would not be as much discrimination. There was also repeated mention of how they got to choose their own doctors with RIte Care, and that now they would have a doctor like everyone else:

> "If you don't have your own physician, your own private doctor, they don't care, they just push you aside."

> "It's a good program because there are many more choices now. Like I didn't want to take (my child) to a clinic. I wanted him to have his own physician who knew him and knew his problems. I mean I was going nuts trying to find a pediatrician who would accept Medicaid, and nobody would."

Complaints expressed by more than one participant included:

- Restrictions on access to emergency care with managed care
- Difficulties in verifying eligibility and plan enrollment with the state's automated verification system
- Frustration with the lack of choice in managed care, particularly concerning pharmacies and hospitals

The written questions on satisfaction levels were not given to the two respondents in the chronically ill focus group. The one member of this group who was participating in RIte Care did express frustration with her MCO, however, particularly concerning the authorization process for using emergency care. The second group member did not have direct RIte Care experience but indicated that she would not have wanted her disabled child to have been enrolled in a managed care plan. Due to her daughter's dependence on a life-support system, she spent considerable time and energy screening physicians and other caretakers on the basis of their attitudes regarding care for severely disabled children. She did not believe an MCO

would have allowed her the latitude in provider choice that she needed. Rhode Island does not include disabled children under RIte Care, however, so this is not really an issue (at least for the present time).

Although there were complaints about the restrictions on emergency care, there was also evidence that the new system was changing behaviors. One respondent told of an occasion when she was experiencing pain over the weekend; she went to the emergency room and had no difficulty getting in. After they kept her for several hours and ran repeated tests, they sent her home without a definite diagnosis, since she was feeling better. About a week later (again on a weekend), the pain returned. This time she decided to wait until early Monday morning to see her primary care doctor. "Now this was on a Saturday morning. I didn't want to go back to the hospital because it costs a whole bunch of money, and I didn't want to abuse my medical, So I waited until Monday and suffered all weekend." As it turned out, she had kidney stones.

ENROLLMENT IN RITE CARE

Since most of the RIte Care enrollees to date qualify under the old-rule groups, most focus group respondents said they heard about RIte Care when they were due for eligibility redeterminations. A few respondents in the urban group, however, indicated that they first heard about the program from friends or relatives.

Some also mentioned the outreach and advertising that occurred in the early months. A couple of the respondents mentioned that they had received a package in the mail that explained the RIte Care program and the choice of health plans. They had also called the toll-free information line (InfoLine) operated by the Department of Health:

> "I had gotten the package from RIte Care, and I called the number . . . and they told me that the physicians that I had been going to, I didn't want to switch doctors, so they told me which plan they were in, and that's the one I chose. And as far as I know, I've had no problems."

> "There was a hot line and an 800 number that we could call to the main office, and they were very, very informative and helpful. We received a packet in the mail which was very descriptive and explained all the benefits. I thought it was handled very well."

There were also some positive comments about the helpfulness of RIte Care staff members. "When I reapplied the last time, that's when it was taken care of right in the office. They had a special lady that was just doing the health plan there was numbers you could call if you wanted to do it yourself, but it just was convenient because she was right there, and we could choose the physician that was on staff that had been seeing the children for a long time. [The RIte Care worker] personalized it. She was a lovely person."

Only one respondent referred to the early start-up problems and enrollment delays. She applied for RIte Care in August, but did not receive her Medicaid cards until December; she received the health plan cards after that. She expressed great frustration with the reliability of the automated eligibility system and also felt frustrated because local Department of Human Services (DHS) staff were never able to give her an accurate assessment of where her case was in the system. She was repeatedly told that she would receive cards, but they never came. "Apparently somewhere along the way my children just got lost from DHS to United." Only after she turned to R.I. Legal Services was she able to get her case straight. She indicated that, although she had a letter saying she was enrolled, providers were not willing to provide services without an official card. "When I didn't have cards, that was the tough part. Most physicians were very reluctant. Most of them said I had to pay at least a portion up front, if they would even allow that."

Several respondents reported frustration with the Medicaid program's system of eligibility verification. One told about how she could not get a prescription filled for her children because the pharmacist was unable to verify her plan enrollment. The pharmacist finally agreed to fill her prescription on a daily basis. Another reported that the major problems with the eligibility system came in the evening, because the system does not operate 24 hours a day. This can cause major problems with emergency situations, particularly when a prescription needs to be filled.

SELECTION OF MANAGED CARE PLANS

Most respondents chose an MCO that included a doctor or clinic they had used before. They also mentioned that RIte Care workers or the InfoLine staff had assisted them in determining the plans in which their doctor or clinic participated. There were no auto-assignments among the focus group respondents.

Some of the urban respondents indicated that their main concern was finding a private doctor so they would no longer have to receive care through the community health center system. Their complaints about the community health centers seemed to focus on their poor recordkeeping.

The major criticism about MCO selection was the fact that respondents liked to select their plans on the basis of not only the primary care provider, but also the pharmacies and hospitals that the MCO used. Several respondents mentioned these other service providers as important factors in their choices.

There were some misperceptions about how managed care works. For example, one respondent selected her MCO because she believed it allowed her to continue to use the emergency room as before, as long as she called the plan to tell them after she'd been there.

RELATIONSHIPS WITH PRIMARY CARE PROVIDERS

As mentioned earlier, a few of the urban respondents indicated that they had changed their primary care providers in the transition to RIte Care. The reported pattern involved moving from a neighborhood health clinic to using a private doctor. However, several respondents indicated they stayed with their primary care providers at the community health centers they had used before.

There were no reports of problems with selecting the primary care provider or scheduling appointments as needed. No one had to change doctors because their previous physician did not participate.

ACCESS TO SPECIALIZED CARE

One concern about managed care is that enrollees may not obtain adequate access to specialized care. However, none of the current RIte Care enrollees reported any problems in this regard. The major complaints related to dental care (which continues to be fee-for-service outside the RIte Care program), and the low number of dentists who were willing to take Medicaid patients. Respondents in the nonurban group particularly cited the availability of a dentist at the local community health center as a very positive development, "When I've tried to go to certain dentists and stuff like that, they've given me a hard time, They really don't want to hear it when it comes to Medicaid. If it's a patient they haven't seen for the last 10 years, they don't want to take in new patients."

COMPARISON TO MEDICAID OR PRIVATE INSURANCE

Few members of the respondent group seem to have had much experience with private insurance, so they mainly compared RIte Care with what they knew under Medicaid. On the positive side, most respondents seemed to feel there was less stigma with RIte Care because you could belong to a Health Maintenance Organization like everyone else, and several felt for the first time that they could now go to a private doctor if they wanted to. On the negative side, many respondents cited concern about their continued access to emergency room care, and several indicated that they were not happy about the restrictions in provider choice, particularly concerning pharmacies and hospitals.

APPENDIX C

PHYSICIAN FOCUS GROUP FOR QUEST

A focus group of QUEST primary care physicians was conducted to gain a better understanding of practicing physicians' reactions to QUEST and to managed care. A range of topics related to QUEST and managed care was discussed. These topics included doctors' relationships with QUEST, managed care plans, and Medicaid; decision-making process on participation; and perceptions of payment levels. Other topics included experiences with changes in patient caseload, perceptions of patients' understanding of QUEST and managed care, and views on quality of care and referral networks under QUEST.

FOCUS GROUP COMPOSITION

Three managed care organizations (MCOs)--AlohaCare, Queen's, and the Hawaii Medical Service Association (HMSA)--and the Hawaii Medical Association (HMA) were given a set of guidelines for selecting physicians for the discussion and were asked to nominate three physicians each.' To gather a group of physicians with relatively similar practices and some experience with the QUEST program, nominated physicians were to be treating QUEST patients and practicing in the city of Honolulu. The managed care plans and the HMA were each asked to nominate three physicians, preferably one internist, family practitioner, or general practitioner, one pediatrician, and one obstetrician/gynecologist. Physicians actively involved in planning or advising about QUEST operations were not to be nominated, because the focus group discussion was intended to be representative of regular, practicing doctors. In addition, staff-model Health Maintenance Organization (HMO), community health center, and hospital-based physicians were to be excluded, because their experiences and issues tend to be quite different from those of independent practicing physicians. All respondents received $100 for participating; only Urban Institute researchers and the physicians were present at the meeting.

In all, 11 physicians agreed to participate in the focus group; 9 physicians attended the meeting held in Honolulu on May 22, 1995. Of the attendees, three were pediatricians, three were obstetricians/

'We did not invite participation from Kaiser or Straub, because their primary care physicians are primarily salaried staff doctors.

gynecologists, and three were either general practitioners or internists. Seven of the nine participants operated individual office-based practices, while the remaining two worked in large group practices. Two had received their medical degrees in the past 10 years (approximately), while the others had earned their degrees an average of 24 years ago.

OVERALL PERCEPTTONS OF QUEST

The overall perceptions of the program among focus group participants reflected these major concerns: the paperwork is a burden; practice style and quality of care have not changed, although the data on costs and use are appreciated; patients do not understand how managed care operates; and the networks lack some physician specialities. The reactions to QUEST among the focus group respondents were neither strongly supportive of nor strongly opposed to the program to date. Four of the nine respondents held somewhat favorable opinions of QUEST. Three others felt the program was moderately unfavorable, while the remaining two had no opinion thus far. One participant remarked, "Things have been going fairly well considering the problems they [DHS] had getting started."

COMPARISON OF QUEST AND MEDICAID

All of the participants had participated in the Medicaid program prior to the implementation of QUEST. The percent of the respondents' patients who were insured by the Medicaid program ranged from 5 to 80 percent. For most respondents, between 10 and 30 percent of their practices came from the Medicaid program. The percent of uninsured individuals seen by the focus group participants was very low prior to QUEST and continues to be about the same (1 percent or less).

Two respondents reported that their overall patient volumes had increased as a result of QUEST; the remaining participants reported that their patient caseload has remained the same. Focus group participants seemed to think that there had not been any significant changes in the composition of patient caseload under the QUEST program.

However, they did complain that, in the beginning, the transition from Medicaid to QUEST upset their caseload size and composition. The turmoil associated with the enrollment and eligibility processes caused problems for primary care physicians, because they were often uncertain as to which patients were assigned to them and which were not. The difficulties in enrollment and eligibility also often disrupted long-standing physician-patient relationships. One participant described the process in the following way: "They [DHS] threw up the marbles and when they dropped down on you [the physicians], you inherited the patients that showed up." Physicians felt that these disruptions not only upset the continuity and quality of care, but also caused further problems in their practices because of the additional time and effort required to develop relationships with new clients. One respondent stated, "In the beginning it was such a mess. I had a set of quadruplets--three of them [were assigned to] me and one of them went somewhere else."

As the eligibility and enrollment processes have begun to improve, patient-physician matches have become more accurate. One focus group participant commented that, although he had lost some patients during the shuffle, they had ultimately returned to his practice.

Some respondents felt that QUEST has been an improvement over the old Medicaid program in reducing physician hopping. That is, the gatekeeper system enables the plans and physicians to control patients' inappropriate use of specialists and primary care practitioners. Others disagreed and noted that changing patient behavior requires a significant amount of outreach and education by the Department of Human Services (DHS), plans, and providers.

Respondents did not seem to think that QUEST's inception has changed health care delivery patterns or patient behavior. One respondent remarked, "I didn't see any change at all going into the QUEST program, except more paperwork." The participants indicated that the preauthorization requirements have not greatly affected the way they practice medicine.

While reimbursement mechanisms have been altered as a result of QUEST, the overall payment levels seem to have remained constant. One participant commented that he appreciated the cash flow resulting from capitated payment methods. Of the nine respondents, six indicated that QUEST payment rates generally equal those of Medicaid, two indicated that QUEST payment rates are generally higher than Medicaid, and one reported lower payment under QUEST. According to the focus group, QUEST reimbursement rates are equal to Medicaid rates on average; however, QUEST rates are often higher than Medicaid rates for certain services and lower for others.

SELECTION OF MANAGED CARE PLANS UNDER QUEST

Table C. **1** shows plan participation of the focus group participants. Eight of the nine respondents participate in HMSA's QUEST product, while six participate in Queen's Hawaii Care. Three participate in QUEST through AlohaCare. All of the respondents saw patients with private HMSA coverage, while eight of the nine saw patients with private coverage through Queen's.

While some of the focus group participants participated in all three managed care plans, the general consensus was that the administrative logistics discouraged an individual practitioner from participating in all three of the non-staff-model HMOs. One respondent remarked, "It just gets too outrageous to belong to too many plans with the preauthorization paperwork--all of the rules and regulations are different--there are different phone numbers to call, different specialist networks, different forms." Some participants commented that they chose to participate in only one (or perhaps two) plans, to limit patient access to their practice. Others claimed that they did not understand the process and were uncertain which or how many plans to select.

There did not appear to be any overarching criteria for physicians' selection of plans. Respondents did often choose to participate in QUEST through the MCO with which they also had private business. The size and name recognition of HMSA probably contributed to the high level of physician participation in HMSA. One physician said that he liked HMSA because they hassled doctors the least. One participant

TABLE C. 1

FOCUS GROUP RESPONDENTS' PARTICIPATION,
BY MANAGED CARE PLAN

Managed Care Organizations	Respondents' Participation
AlohaCare	3
HMSA	8
Queen's Hawaii Care	6

"Five of the respondents participated in two managed care plans, two participated in three plans, and two participated in one plan.

noted that he did not choose AlohaCare because he was unfamiliar with the plan and did not know what to expect in terms of regulations, reimbursement, and provider relations. One respondent stated, "I think a lot of physicians chose plans that guaranteed them or reassured them that they would NOT be flooded with Medicaid [QUEST] patients . . that is probably why the status quo has been kept." One physician in a group practice noted that he personally did not choose to participate; it was a practice-level decision, and he just went along. Most of the respondents acknowledged that they did not always understand their MCO contracts or terms of participation; sometimes they just signed the contracts and hoped things would go all right, and sometimes their business managers knew the details about insurance arrangements.

PAYMENT ISSUES

As noted previously, the respondents did not view the level of reimbursement under QUEST as considerably different from Medicaid rates prior to QUEST. For payment, respondents had agreed to a number of different arrangements, ranging from fee-for-service to fully capitated, with the managed care plans. Four individuals had contracted on a fee-for-service basis with HMSA, and five had agreed to fee-for-service reimbursement from Queen's Hawaii Care. The other arrangements were predominantly partial-capitation arrangements.

Focus group participants, operating under some form of capitation, were basically satisfied with the timeliness of payments and the cash flow. Others, who had fee-for-service arrangements, complained that the plans were often late in their payments and were often not cooperative in resolving the issue. According to one participant, "When you don't get paid, you don't even know who to call." Another participant stated that she had heard of a few pediatricians dropping out of the QUEST program due to significant reimbursement delays. According to a few respondents, some plans have established electronic billing systems, which expedite claims submission and processing.

OTHER MANAGEMENT ISSUES

The most troublesome issue brought about by the implementation of QUEST concerns referrals and the additional documentation required under managed care. Participants agreed that the administrative hassles were an intrinsic part of any managed care program, not just a problem unique to QUEST: "For instance with Queen's Island Care [a private IPA model managed care product]--they notoriously gave us hassles--they were the ones you least wanted to call about anything."

The resources required to make a referral varied, depending on the type of service needed. Focus group respondents agreed that the referral process for routine procedures or services was straightforward and required little effort and time (about 20 minutes). When ordering a special diagnostic test, referring to a hospital, or dealing with a particular provider who may not be in the network but is the only available provider, the referral process was lengthy (several hours) and onerous.

Participants also stated that the administrative burdens QUEST imposes are aggravated by the various guidelines for referrals and authorizations used by the different plans and the lack of adequate information and plan support. The referral and authorization protocols that each plan set forth often were internally inconsistent, and the information was not adequately disseminated to the providers responsible for knowing and applying the policies. One respondent stated, "You call one person one day and they might give you one answer then you call another person another day and they give you a totally different answer." Participants felt strongly that the provider relations representatives for QUEST are often undertrained and less helpful than representatives for private insurance products: "At HMSA, there doesn't seem to be anybody who can answer your questions when you call--they always have to check with someone else and then they never call back." Another said, "[Plan] service in QUEST is worse than on the commercial side there is no training for their [provider representatives]." Participants remarked that, to get answers from the plans, providers had to have contacts with the upper management: "It gets to be like an old boys' network."

Some of the managed care plans do not seem to be managing care. While focus group participants found the administrative duties cumbersome, they remarked that the plans' management teams were not exercising true managed care. In some plans, authorizations were rarely denied. One respondent commented, "I would like to question the whole validity of managed care [under QUEST], because I don't hear that very many people have been turned down for most things [services]." A few felt that the managed care component of QUEST may be evident in the limitation of patients seeking care from numerous physicians.

An aspect of the QUEST program that respondents generally appreciated was the utilization and cost data the plans provided to them. One respondent remarked, "One thing I've noticed about QUEST that I really like is that we actually see the costs." Not all of the plans had provided physicians with data, however. Often the data provided were not in the context of their peer group and, consequently, were not very useful.

PATIENT RELATIONS

All of the respondents agreed that QUEST members essentially do not understand the concept of a primary care physician and managed care in general; this causes a range of administrative problems for physicians and specifically for primary care physicians. Respondents stated that they often spend a good deal of time discussing managed care and the gatekeeper model with their QUEST patients. They commented that neither the DHS nor the managed care plans have made efforts to educate QUEST enrollees. "At no time were they [the patients] ever told this is your PCP. You are going to have to contact your PCP before you do anything--before you go to the hospital or do anything else."

Participants felt that the implications of the lack of education are that the QUEST enrollees do not change their behavior. For example, they continue to use the emergency room for nonurgent medical needs: "Some of my patients are still going to the ER for a sore throat." Some respondents also felt that incentives to discourage inappropriate use of medical services are insufficient in QUEST.

QUALITY OF CARE

The participants remarked that they did not perceive any major changes in their practice methods since the implementation of QUEST. However, participants agreed that the scarcity of certain physician specialists (such as neurologists and orthopedists) in the QUEST provider networks may affect quality of care. They also state that quality of care may be affected by how well the network operates and the procedures required for special cases. Participants claimed that, given the formularies and other restrictions, pharmacies have not helped facilitate care in special situations.

Some participants commented that, over time, the types of health, welfare, or social services available to needy people were eroding (not necessarily due to QUEST). They stated that the Department of Health (DoH), DHS, and the plans often claim that support services or case management activities are no longer their responsibility. As a result, the physician must try to coordinate other services to facilitate the provision of medical care. One respondent described a situation in which his patient needed child care so that she could receive treatment. The physician's office sought aid from Catholic Charities to provide the child care; under the old system, such care would have been coordinated or provided through DHS or DoH. While the plans claim that caseworkers are available to assist with noncompliant patients or with enabling services, the participants stated that the needed support systems were not easily accessible or operational to their knowledge: "There's no emergency rescue system now . in the old days with DHS, you could call their [the patients'] caseworker and get them to help you . . there doesn't seem to be anyone to do that anymore."

APPENDIX D

HAWAII CONSUMER FOCUS GROUPS

To learn the views of QUEST clients and some low-income uninsured people, we held three focus groups in Honolulu and Kona in May 1995: (1) an urban low-income group, (2) a rural low-income group, and (3) an urban group of people with chronic health problems. The focus groups are not a statistically representative sample of QUEST clients or uninsured people, but are still a broad cross-section of the QUEST clientele, including some with relatively high health care needs and some low-income uninsured people. Respondents discussed their experiences with QUEST and the health system, including how they selected managed care organizations (MCOs) and primary care providers, their access to specialty care, and comparisons between QUEST and other insurance.

COMPOSITION OF CONSUMER FOCUS GROUPS

Local organizations helped to recruit focus group members.[1] Following protocols that we provided, the local organizations identified, contacted, and obtained agreements to attend from a total of 3 5 people. To help offset the costs of participation, we offered $25 in cash for attendance. We also promised confidentiality. Twenty-three people actually showed up for the meetings: 8 in the urban low-income group, 10 in the chronically ill group, and 5 in the rural low-income group. One-third (34 percent) of those who agreed to come did not show up.

The 23 respondents included 18 QUEST clients, 2 former QUEST clients and 3 uninsured people. Twenty respondents were female and three were male. Table D. 1 shows other descriptive data.[2] Most respondents had low income, although many had incomes above poverty.

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[1]The facilitating organizations were: (1) Urban Low-Income: Med-QUEST Eligibility Branch in Honolulu and a community health center; (2) Chronically Ill: Alliance for the Mentally 111, Zero-to-Three (program for developmentally disabled) and a central city medical clinic; and (3) Rural Low-Income: Med-QUEST Eligibility Branch in Kona (uninsured drawn from QUEST applicants pending approval).

[2]Tabular data in this chapter are based on responses to a short questionnaire administered before the discussions began. Therefore, they should be unaffected by any opinions expressed during the discussions.

TABLE D. 1

BACKGROUND CHARACTERISTICS OF THE 23 FOCUS GROUP RESPONDENTS

Trait	Number
Race/Ethnicity	
White	10
Asian/Pacific Islander	9
Hispanic	1
Other	1
Receipt of Public Assistance:	
AFDC	7
General assistance	4
SSI	2
Prior Receipt of Public Health Insurance:	
Medicaid	8
GA Medical care	4
SHIP	2
Family/Household Size:	
One	5
Two	6
Three	5
Four	2
Five	3
Six	1
Income Poverty Level Last Month (Percentage):	
0 to 50	4
51 to 100	7
101 to 150	7
151 to200	1
200 to 250	1
Refused or don't know	3

AFDC = Aid to Families with Dependent Children; GA = General Assistance; SHIP = State Health Insurance Program; SSI = Supplemental Security Income.

Table D.2 summarizes the insurance status of the respondents and the other members of their families or households. A surprising level of complexity exists in households' insurance arrangements. It is relatively common for a portion of the household to be on QUEST, while others are privately insured through work, are uninsured, or are on Medicaid (due to disability). Since the Prepaid Health Care Act requires that workers, but not dependents, be covered, QUEST is sometimes used only for the uninsured members of the family. Sometimes, some members of a QUEST household are uninsured because they do not want to pay the premium. In one case, a mother and two of her children were on QUEST, but the mother's severely disabled daughter was uninsured because she was too disabled for QUEST. Although the daughter was on Supplemental Security Income, she was not eligible for fee-for-service Medicaid because the family's assets were too high under Hawaii's rules. Thus, the family member with the highest medical needs was uncovered. The child was on the waiting list for a special Medicaid home- and community-based health care waiver project.

Respondents or their families had many serious health problems; these were most pronounced in the chronically ill group. Collectively, we encountered 3 severely disabled children, 3 people with diabetes, 10 people with asthma, 1 chronically depressed person, 2 recovering drug/alcohol addicts, 1 developmentally delayed child, 1 person who recently had maternity complications, 1 person with cardiac problems, 1 person who recently had a stroke, and 1 person with neurological problems (some people had more than one problem). Some were relatively healthy and used little medical care.

The respondents collectively represented members of all five medical plans and both dental plans (see Table D.3). Compared with the overall plan enrollment levels, representation of Hawaii Medical Service Association (HMSA) members was lower than expected, and representation of AlohaCare members was higher (in part because those recruited by a community health center were all on AlohaCare).

TABLE D.2

INSURANCE STATUS OF 23 RESPONDENTS AND THEIR FAMILIES/HOUSEHOLDS

Insurance Status	Number
Respondent on QUEST and:	
Lives in one-person household	4
All other household members on QUEST	8
Some other household members on QUEST, but some uninsured	1
Some other household members on QUEST, one on Medicaid (due to disability)	2
No other household member on QUEST, others privately insured	1
No other household member on QUEST, others uninsured	1
Respondent not on QUEST and:	
Respondent uninsured, lives in one-person household	1
Respondent uninsured, other household member privately insured	1
Respondent uninsured (was briefly on QUEST), one other household member uninsured, one other household member privately insured	1
Respondent privately insured, but other household members on QUEST	1
Respondent privately insured but wants to drop and get QUEST, other household member privately insured	1
Respondent privately insured, but other family member on Medicaid (was briefly on QUEST)	1

TABLE D.3

MEMBERSHIP OF RESPONDENTS AND OTHER FAMILY MEMBERS IN QUEST MCOS

Plan Type and Name	Number of Respondents in MCOs	Total Number of Other Household Members in MCOs
Medical Plans		
AlohaCare	6	10
HMSA	6	2
Kaiser	2	8
Queen's	3	4
Straub	2	4
Don't know	0	1
Dental Plans		
DentiCare	6	5
HMSA	11	17
Don't know	2	7

OVERVIEW OF CONSUMERS' CONCERNS

Most members of the urban and rural low-income focus groups were satisfied with their new arrangements in QUEST, although there were some significant exceptions or problems. The chronically ill group was less favorable about QUEST and the medical care they received. Table D.4 summarizes the groups' responses to two general questions about satisfaction with their medical plan and the physicians or nurses seen while on QUEST.

People generally liked the medical care they received but sometimes had complaints about QUEST enrollment or plan administration. Typical complaints included:

- Delays in QUEST enrollment
- Not being assigned to the MCO selected
- Delays getting membership cards from their MCOs
- Not being assigned to the primary care physician or dentist requested, which sometimes meant that they had to change their regular doctor or dentist
- Some doctors (especially specialists) and dentists do not participate in any QUEST plans; in addition, some doctors said they were no longer accepting QUEST patients.
- Neither the state nor MCOs gave much information about how managed care worked or how to select plans or primary care providers.

Some people in the chronically ill group mentioned cases in which care was delayed or in which they felt the medical care received was suboptimal, although there were no reports of serious medical problems caused by difficulties with QUEST.[3]

[3]Verifying the problems mentioned in the focus groups was not possible. It is plausible that some of the reports are exaggerated or that there were extenuating circumstances that were not brought up.

TABLE D.4

GENERAL SATISFACTION WITH MEDICAL PLANS AND PHYSICIANS IN QUEST

Questions	Urban and Rural Low-Income Groups	Chronically Ill Group
Overall, how satisfied have you been with the medical insurance company that you used while you were on QUEST?		
Very satisfied	4	1
Somewhat satisfied	2	5
Somewhat dissatisfied	0	2
Very dissatisfied	1	0
No opinion	3	1
Overall, how satisfied are you with the physicians or nurses that you have seen while you were on QUEST?		
Very satisfied	8	3
Somewhat satisfied	2	3
Somewhat dissatisfied	0	3
Very dissatisfied	0	0

ENROLLMENT IN QUEST

People typically heard about QUEST in one of three ways: (1) they were on Medicaid, General Assistance (GA), or the State Health Insurance Program (SHIP) before and were told to change; (2) they were referred by a health care provider; or (3) they heard through a friend or through work. Most felt that QUEST was relatively well known in their communities, despite its newness. Those who converted from prior Medicaid, GA, or SHIP did not report any problems in being approved to participate. In contrast, more recent joiners or those waiting for QUEST benefits complained about the delays. It often took several months between the time that a person first applied and the time that an MCO membership card was finally received.

Another problem was difficulty in getting information. One woman stated, "When I call over there [the QUEST office], they say I don't know. You have to wait 10,000 rings before they pick up." On the other hand, one woman mentioned, "[a 2- to 3-week wait for QUEST] is a marked improvement over the SHIP program which took 6 to 9 months to get an appointment."

In general, people felt that the Med-QUEST eligibility staff was helpful and friendly. "I thought workers treated me with a lot of respect." (In other projects, we have typically found that. welfare recipients believe their eligibility workers treat them badly.)

Four people paid premiums and said the premiums were fair. However, one former QUEST client quit the program because she was not assigned to the provider she requested and because her premiums were twice as high as she had been told at first. She commented, "I was told that it would be $140 a month. When I got my first bill it said $283 a month, which I cannot afford. And it is more than regular insurance." (It seems likely that the premiums were higher because of changes in her income between the time she first applied and the time she was finally approved.)

SELECTION OF MANAGED CARE PLANS

In selecting a managed care plan, QUEST clients generally tried to choose a health plan that included a doctor they used. Some people chose the health plan they had before, either HMSA (the previous Medicaid carrier) or Kaiser. Many relied on advice from health care providers about which plan to join; for example, community health centers would typically recommend AlohaCare. Others were automatically assigned to a plan because they did not choose a plan in time.

Some complained that the state provided almost no information about what managed care was or how to pick a plan. In the initial mass enrollment for prior Medicaid, GA, or SHIP clients, people only received short brochures describing each plan. As one woman said, "[The brochure gave] no information about the particular plans. The application just said choose: first choice, second choice . . . There was a real void in information." In another group we heard, "It doesn't say a thing about how it works. It says you get A, B, and C. You send it in or you're out." One woman realized that she was partly responsible for problems: she did not read the materials at first and filed them away; only later did she realize the importance of the materials sent to her.

Because of a lack of clearer information, there were some misperceptions. For example, one person did not join one plan because she believed that it was not accepted at her hospital. This was probably untrue.

Some people were frustrated because they were not enrolled in the plan they selected. For example, one woman selected Kaiser but was assigned to Straub (probably because Kaiser had reached its cap level).

There were some delays in getting MCO membership cards. Some said they got a card relatively quickly (in a couple of weeks), while others said it took as long as 9 months. There were no reports of serious problems that occurred because of the lack of a card. In some cases, people who required medical services were able to verify membership on a timely basis, using phone calls to the QUEST office.

RELATIONSHIPS WITH PRIMARY CARE PROVIDERS

For most of the respondents, the primary care physician is their main caregiver. Many did not report problems and said they got the doctors they wanted or had no strong preferences. However, a large minority of respondents experienced difficulties getting the physicians they wanted or had to change primary care physicians. Several had comments such as, "I said who I wanted [for a primary care physician]. He was on the list. But when I got the card, it was someone else." A woman with diabetes reported one extreme case: "I found out about QUEST when I was in the hospital the day before I had an amputation on my toe [because of diabetes]. They came in and told me that I had another doctor and that the surgeon and all the other doctors that saw me I no longer had any access to. . . . I lost a lot of other doctors that I had on HMSA when I changed over. It's been one thing after another." She felt that her new doctors provided satisfactory care, but was nonetheless upset that she lost relationships with most of the doctors she had been seeing for years.

Some providers were automatically assigned by the MCO. Sometimes the MCO assigned inappropriate doctors. For example, "My neighbor, a 76-year-old man . . . they assigned him a gynecologist." Much of the confusion regarding assignment of primary care physicians may have been due to the disorder of the first mass enrollment and may have abated since then.

Some respondents had to change doctors because their previous physician did not participate in QUEST at all, did not participate in a specific plan, or was not taking further QUEST patients. Some respondents had to call several doctors to learn who was on QUEST and who was willing to take them. One mother stated, "There are only some doctors who are willing to take your kind of kid." One woman had to change doctors because she selected her family's plan based on her children's doctors (who were with Straub), and her previous doctor was in another plan. She has not seen the primary care physician assigned by her MCO. "I was just working on some things and I wasn't comfortable with seeing another doctor, so I haven't gone to see anyone else." She was happy with her children's doctors, however.

Few problems were mentioned regarding the selection of primary care dentists. Only one woman complained about losing her previous dentist. After joining QUEST, she continued to pay out of pocket for dental care for her children, noting, "My focus for my children is [finding a nice dentist]. If they're scared they won't go and that's it."

Although most respondents felt that they liked the medical care they received, a few complained that they had a harder time getting an appointment or were treated more rudely by waiting-room staff members than those with private insurance. "If you have private insurance, you get a better attitude [from the receptionists or nurses]." Sometimes this attitude was compounded because some respondents were embarrassed by being on a public assistance program.

Two respondents mentioned that they had problems getting appointments with or did not like their new primary care physicians; therefore, they had returned to see their old doctors on an out-of-plan basis. One woman was not assigned to the community health center that she requested, so she continued to go there and paid for care on an out-of-pocket basis using their sliding-fee scale for uninsured people. However, others said that they could not afford to pay for care out of pocket and only went to plan doctors.

ACCESS TO SPECIALIZED CARE

An important element of managed care is controlling access to specialized care, including specialists and hospital care. In many cases, consumers expressed satisfaction with their care. One man who had chronic mental-health needs commented, "On the level of therapy for me . . I've been very fortunate." The husband of a woman who had to stay in the hospital for a month because of maternity complications was very pleased with the program: "Her doctor was great and they paid for everything--the whole time."

Nonetheless, a variety of problems were reported. One concern was that the choice of specialists was sometimes inadequate or that plan specialists are rarely available. A woman with a chronic problem said, "I got a very nice [specialist], but he only comes to the clinic once a month'on Tuesday. So for the rest of

the month I can't get any care." A more widely expressed concern was the delay in getting referrals to specialized care. One woman said (to broad agreement from the group), "It takes three months to get an approval [to see a specialist or for tests]."

Another woman cited the inconvenience of some of the care arrangements: "My son had to get X rays. There was an X-ray lab right down the hall [from his primary care physician], but they didn't take the Queen's So he had to jump on the bus to go downtown to get X rays."

Some people deferred care because of perceived problems with the referral process: "I needed physical therapy for my knee. But because I had so much trouble [with QUEST], I've just been living with it. It's too much trouble to ask for a referral from this hospital that I don't even know,"

One woman cited a case in which her primary care physician was unwilling to refer her for an X ray or to a specialist, so she had to pay $300 out of pocket for an X ray to prove to her primary care physician that she had a problem that required specialized care. Another woman reported that she had had a stroke and when she went to one hospital in the ambulance, they refused to take her and referred her to another hospital, which was affiliated with her plan.

One problem appeared to be related to plan restrictions for provider payments. One woman had problems with her Norplant birth control implant and wanted it removed. The physician was unwilling to remove it because the MCO did not pay separately for early removal, despite her problems. She complained to the MCO and the state and finally received approval for Norplant removal; she was now seeking approval for an operation to be sterilized. However, it took hours of phone calls to get these authorizations

COMPARISON WITH MEDICAID OR PRIVATE INSURANCE

Overall, perceptions of QUEST were mixed. Most respondents had been on Medicaid, and many also had had private insurance before QUEST. There were positive comments such as, "I'm real grateful for having the medical program" and "I have no problems with the program."

Others, especially those in the chronically ill focus group, appeared to have preferred Medicaid to QUEST, primarily because there were fewer restrictions in seeing doctors. One person summarized his view as: "QUEST is health care for people who don't need to see the doctor." A woman whose disabled daughter was on Medicaid was very concerned about the problems that she might encounter if managed care became applicable to the disabled: "I don't want QUEST II [the planned shift of disabled people into managed care] to come up. I'm scared." (Since details of the plan for QUEST II were not known at this time, her concerns were general instead of specific.)

One woman who had chronic health problems had only one complaint about QUEST: she now had to make copayments for her prescription drugs, which had been free under Medicaid.

Other respondents objected to some of the underlying premises of managed care, such as needing authorization from a primary care physician. One person commented, "I [don't like] to have to ask permission from someone else to go to the doctor I want to go to." Another said, "Private insurance is better because you can go to any doctor you want. But the good thing about [QUEST] is that you don't pay any premiums."

HEALTH CARE ALTERNATIVES

Respondents spoke of three alternatives to health care provided through QUEST: (1) going to certain clinics, including the Queen Emma Clinic in Honolulu and community health centers; (2) paying out-of-pocket for occasional visits to doctors or other health care providers; and (3) purchasing private health insurance. In general, the uninsured people we met wanted to get into QUEST but were not yet enrolled because of delays.

Although we expected that health care alternatives would be most important to the uninsured, we learned that even QUEST patients sometimes obtained separate care. As mentioned previously, people sometimes felt the need to see a nonplan provider and were willing to pay some providers out of pocket. One respondent preferred holistic health care and frequently used alternative health, care providers (for

example, naturopaths). He and his family only used QUEST medical services for emergencies, diagnostic medicine, and prescription drugs. One unemployed woman was paying for private health insurance but wanted to convert to QUEST. She had required surgery at the time her seasonal job ended, and she had arranged with her employer to maintain coverage. Since her family income was very low (around the poverty level), she was not able to afford her premiums.

APPENDIX E

URBAN PHYSICIAN FOCUS GROUP IN TENNESSEE

GROUP COMPOSITION

Ten physicians participated in the focus group in Memphis in June 1995. The group included two internists, three obstetricians/gynecologists, two family/general practitioners, and three pediatricians. Their practice settings included solo private practice (two), small group private practice (three), large group private practice (three), staff-model Health Maintenance Organization (HMO) (one), and academic setting (one). The physicians were recruited from lists of participating physicians provided by managed care organizations (MCOs) operating in Memphis and through hospital contacts made by the local focus group facility where the focus groups took place. Among them, the 10 physicians represented all six plans operating in Memphis (see Table E. 1). Physicians were offered an honorarium of $100 to participate in the focus group, which took three hours.

OVERVIEW OF PARTICIPANTS' CONCERNS

The physicians thought that TennCare was a good idea, but one that had been instituted too quickly and with resulting problems. The physicians' principal issues were related to (1) medical concerns (especially declining prenatal care and the difficulty of getting specialty referrals), (2) administrative concerns (especially the difficulties of dealing with multiple and changing bureaucracies and the continuing problems of figuring out which plan a patient was enrolled in), (3) payment concerns (these varied with the plan), and (4) the future (especially whether The Med would survive, and whether Access MedPlus would go bankrupt).

COMPARISON OF WAIVER AND MEDICAID

Before TennCare, most of the physicians were seeing uninsured patients, but only 7 of the 10 saw Medicaid patients. The number of Medicaid patients these seven physicians saw varied from 3 percent to 60 percent of their patient load; only one limited the number of Medicaid patients in his practice. Only

TABLE E. 1

CHARACTERISTICS OF PHYSICIAN FOCUS GROUP PARTICIPANTS

Specialty	Number	Payment	Number
Internal Medicine	2	TennCare pays more than Medicaid	3
Family Practice/General Practice	2	TennCare pays the same as Medicaid	2
Obstetrics/Gynecology	3	TennCare pays less than Medicaid	3
Pediatrics	3	No opinion/No response	2
Years of Graduation from Medical School		Preferred to deal with Medicaid than TennCare	5
1950s	3	I prefer to deal with the plans	1
1960s	1	It's about the same	2
1970s	2	No opinion/No response	2
1980s	4		
Practice		TennCare has increased my patient volume	5
Solo	2	My volume has stayed about the same	3
Small group (fewer than 10)	3	My volume has declined	1
Large group (more than 10)	2	No response	1
Staff-model HMO	1		
Academic setting	1	Overall Opinion of TennCare	
No response	1	Somewhat favorable	1
Participated in Medicaid Before TennCare		Neutral	1
Yes	7	Somewhat unfavorable	3
No	2	Very unfavorable	4
No response	1	No response	1
Percent of Patients on Medicaid			
1-10	1		
1 l-20	2		
21-40	1		
41-60	3		

one Medicaid MCO operated in Tennessee before TennCare, and only one of these physicians participated in it.

The physicians compared TennCare unfavorably with Medicaid. Medicaid was a known quantity, payments were known, and specialty referrals were not too difficult. Experience with TennCare has been dramatically different. The physicians cited numerous problems, including the difficulty of getting specialty referrals, payment levels and speed of payment, and confusion about patient eligibility. They also spoke of the chaos of the first few months of TennCare. Furthermore, they feel there is more paperwork under TennCare and just as many rules as with Medicaid.

SELECTION OF MANAGED CARE PLANS

The physicians had elected to join from one to five plans (out of a potential total of six). The one physician who had experience with Medicaid managed care signed up with that plan because his earlier experience with it had been good. Some physicians had signed up with particular plans because their medical group had done so; some signed with several plans to ensure maximum access for their patients.

Physicians received information about the plans through the state, the plans, and their professional associations, The plans provided little information. One of the physicians met with the president of the Phoenix plan before signing. Physicians said they had little or no room to negotiate their contracts with the plans (although some physicians had negotiated their capitation payments with the MCOs).

However, there was general agreement that the TennCare philosophy--with an improved primary care base--was a good one, although implemented too fast. Physicians recommended higher capitation payments when individuals are first enrolled because of the lack of preventive care they have received: "With the TennCare patients that are coming in as adults, they are train wrecks. They are so sick and so acutely ill it's going to be a long time before physicians can start making inroads in preventive medicine."

PAYMENT ISSUES

A major concern was nonpayment because of enrollment problems: "They have cut costs, they just haven't paid for what's going on." There are different payment issues for different plans. The three largest plans in Memphis are Blue Cross/Blue Shield, OmniCare, and Access MedPlus (which, combined, had 80 percent of enrollment in Memphis in April 1995). The physicians considered that Blue Cross paid efficiently, but paid too little. They also commented that Blue Cross did not give them enough information about how much copayment they could collect from members with different copayment codes on their membership cards. In contrast, they considered that, while Access MedPlus paid adequate rates to primary care physicians, it did not pay in a timely manner or in a way that enabled physicians to identify for whom or what they were being reimbursed. Although this payment problem is not as acute as when TennCare began, the physicians believed that Access MedPlus is not financially sound, because it has not demonstrated that it knows how much money it owes to providers. The physicians were critical of the state for allowing Access MedPlus to operate in this way for so long.

This group of physicians reported varying payment methods (see Table E.2). The variability within the plan may be due to the mix of primary care and specialty physicians, who often have different payment methods.

The physicians were infuriated by the amount of advertising the MCOs undertake, especially around the time of open enrollment. This is because physicians see advertising as money diverted from medical care.

The physicians noted that, although primary care physicians are now being paid relatively better than specialists, they did not consider it possible to run a practice with TennCare patients only. This is because the payment rates (except for those of Access MedPlus) were too low.

TABLE E.2

PHYSICIAN PAYMENT METHODS

Method	Access MedPlus	Blue Cross/ Blue Shield	OmniCare/ Affordable	Phoenix/ Advantage	PruCare	TLC
Fully Capitated	1					
Partially Capitated	1	1	1	1	2	1
Case Management Fee Plus Fee-for-Service		1				
Fee-for-Service	1	2	1			1
Fee-for-Service with a Withhold or Bonus		3			1	2
Other	1		1			
Don't Know						

OTHER MANAGEMENT ISSUES

The physicians were outspoken about several management problems: the difficulty of knowing which plan a patient is enrolled in, the pressure to have multiple hospital affiliations, drug formularies that differ across plans and keep changing, and difficulties getting action from plans when a problem is encountered. Several physicians were taking patients without payment because the patients were enrolled in plans the physicians weren't contracted with; their patients will change plans at the next open enrollment.

Patient possession of an enrollment card is no guarantee that the person is enrolled in that plan. All of the physicians had encountered patients with multiple membership cards. All physicians in the group had office staff assigned to check eligibility even when the patient has only one card, because of their experiences with denied payments for patients who appeared to be (but were not) members of a plan. Although the physicians admitted that it was worse at the beginning of TennCare, these problems are not resolving. Newborns are not getting membership cards smoothly. The mother is responsible for getting the card. Pediatricians at the hospital see the child when it is born, but it is not covered after that unless the mother gets it a card. Doctors reported that newborns sometimes get assigned to different plans than the rest of the family; in one case, twins were assigned to different plans.

A consequence of participating in managed care plans is that physicians have to admit plan patients to the hospitals participating in that plan. The focus group physicians did not like to admit to multiple hospitals because it takes extra time to do rounds. However, because some hospitals were dropping Access MedPlus (they mentioned Baptist) they were having to admit to multiple hospitals until the next open enrollment period (when their patients could switch plans).

The physicians complained about the difficulty of having to use different formularies for every plan and the fact that the plans constantly change formularies. They also complained that the staff members at the plans who handle telephone request for exceptions from the formulary were sometimes ignorant and often put them on hold for long periods.

Access MedPlus came in for particular criticism about assignment of different family members to different physicians. Early in TennCare a lot of inappropriate physician assignments occurred (for example, 90-year-olds assigned to pediatricians).

PATIENT RELATIONS

Five physicians had increased their total patient volume since they participated in TennCare. One physician commented that, of the 500 TennCare patients he is managing, he has seen only a minority; when he does see them for the first time, however, they are in need of a lot of care. The doctors said they were the only people providing patient education about managed care and recommended that the MCOs be required to provide this education, particularly concerning criteria for using the emergency room.

QUALITY OF CARE

Physicians talked about three quality-of-care issues: (1) what the lack of access to specialists was doing to quality, (2) access more generally, and (3) the reduction in hospital services.

The doctors complained most about the extreme difficulty they were having getting referrals to specialists for their TennCare patients (especially orthopedic surgeons and neurosurgeons). This was frustrating for them, and they said they spent a lot of time trying to arrange specialist referrals. One physician said that a consequence of his spending so much time on his TennCare patients was that his private patients were leaving the practice because they were having to wait longer to see him than they liked. Only the physician in the Prudential staff-model HMO plan had no problems getting specialty referrals.

The physicians were convinced that they had much worse access to specialists under TennCare than under Medicaid, and that the cram-down provision and low specialty payments are the major reasons why the specialists are not participating in TennCare. Consequently, the primary care physicians are providing some services themselves that they would prefer a specialist to provide (setting bones was one service that

two doctors mentioned), or else they call in favors from specialists to get the patient seen. They spend less time in direct patient care when they have to spend so much time negotiating a specialty referral.

Obstetric and pediatric physicians were concerned that, when a patient is seen in the hospital (at the time of delivery), they cannot follow up with the patient afterward because the patient must go back to the primary physician. They feel patients were not getting the best possible followup by the primary physician. Some physicians believe that prenatal care has gotten worse, both because physicians can no longer assume that pregnant women are presumptively eligible and because women don't know the physician to whom they are assigned.

The physicians also remarked that the networks of the two largest plans were problematic (although for different reasons). The Blue Cross network included physicians who no longer practiced in the area (one pediatrician stated that, of 50 pediatricians listed by Blue Cross in Memphis, only 6 were accepting TennCare patients) and excluded physicians who refused to accept the "cram-down" provision. The Access MedPlus network was incomplete at the start of TennCare; because of the poor claims-paying record, specialty physicians have not been attracted to the network.

The physicians were also concerned about what TennCare may do to hospital services in Memphis. All were concerned that The Med would close down, thus removing the key source of care for high-risk pregnancies and other subspecialty services

RECOMMENDATIONS

These physicians recommended changes to improve TennCare, including getting rid of the cram-down provision, paying higher capitation in the period when a patient first enters TennCare, allowing only one or two MCOs to operate in an area, and requiring plans to educate their patients about managed care. They also suggested having the state monitor the plans' performance more closely and take action against poorly performing plans, disallowing excessive advertising by plans, and requiring patient copayments for those who abuse the emergency room.

APPENDIX F

CONSUMER VIEWS IN TENNESSEE

To learn the views of TennCare clients about the TennCare program, we conducted three consumer focus groups in June 1995, one made up of disabled consumers and two made up of low-income consumers. Two of these focus groups (low-income and disabled) were held in Memphis (Shelby County), and the other low-income group was held in a nearby rural area (Somerville in Fayette County).

SELECTION METHOD AND COMPOSITION OF FOCUS GROUPS

The focus group members are not a randomly selected group, but we believe they are representative of TennCare enrollees. The TennCare Bureau provided us with an address list of low-income and disabled consumers in Memphis. It had created these lists of enrollees by selecting every nth enrollee to yield 100 names from the eligibility files. After attempts to contact these consumers by phone proved difficult, we sent all of these consumers an express letter asking them to call a telephone number if they were interested in participating in the focus group. The telephone number was for a focus group facility in Memphis that coordinated recruiting. The focus group facility screened the callers and explained the purpose and time of the focus groups, as well as the incentive for attending (a $25 payment). We recruited the rural low-income group with the help of the Department of Human Services (DHS) outreach worker.

The focus groups included 19 people (5 in the disabled group and 7 in each of the two low-income groups). The focus group members were predominantly women (the disabled group included one male), and all groups included a mix of black and white consumers. The low-income groups included both expansion group and "old-rule" consumers. One consumer was enrolled as uninsurable on the basis of a letter from an insurance company stating her uninsurability. Household size ranged from 1 to 18, and all of the families had incomes 200 percent or lower than the federal poverty level (see Table F. 1).

The health status of the focus group participants varied, with the disabled group having the most severe problems (lung cancer, diabetes, severe arthritis, heart condition, permanently injured shoulder, permanently injured ankle, and a developmentally disabled child). The rural group also had some significant health problems (one participant was in the TennCare "uninsurable" category). Their health

TABLE F. 1

BACKGROUND CHARACTERISTICS

Race/Ethnicity	
White	12
Black	7
Public Assistance	
AFDC	2
SSI	3
SSDI	6
Prior Receipt of Public Health Insurance	
Medicaid	12
Family/Household Size	
1	3
2	3
3	1
4	5
5	1
6	2'
7	1
8	1
18	1
No response	1
Income as a Percent of the Federal Poverty Level	
0-50	4
51-100	6
101-150	3
151-200	2
Refused/Don't know	4

[a] Respondents reported SSDI, but some of them appear to be SSI

AFDC = Aid to Families with Dependent Children; SSDI = Social Security Disability Insurance; SSI = Supplemental Security Income.

problems included asthma, kidney problems, arthritis, headaches, mental disability, and high blood pressure. One reported blindness in a family member.

Six managed care organizations (MCOs) operate in Shelby County, but only the two statewide plans (Blue Cross and Access MedPlus) operate in Fayette County. We had members of all but one of these plans in our focus groups (see Table F.2). (PruCare, which was not represented, is one of the smallest plans in Memphis.)

OVERVIEW OF PARTICIPANTS' CONCERNS

The level of satisfaction with TennCare was fairly high; the rural group seemed more satisfied than the groups in Memphis with the care provided by TennCare. Specific problems the consumers raised had to do with TennCare administration, physician choice, physician quality, prescription drug coverage, dental access, and access to primary care physicians. The disabled group, although generally satisfied, had some particular concerns; some of them thought Medicaid was better than TennCare because it allowed more physician and hospital choice.

ENROLLMENT INTO TENNCARE

The consumers had heard about TennCare from a variety of sources. These included health care providers, television advertisements, DHS caseworkers, an employer's insurance benefits coordinator, and a recruiter for one of the plans. Some of these sources were instrumental in the consumers' enrollment in TennCare. Several of the urban consumers who had been in Medicaid before TennCare said that they had been switched over automatically with little problem. Some, however, thought enrollment was confusing, One said, "For some reason they told me I had to be approved for Medicaid before I could get approved for TennCare; I didn't understand that."

Compared with the time of startup, consumers understood retrospectively much more about the enrollment process and what kinds of choices they could have made. Comments on the caseworkers who

TABLE F.2

FOCUS GROUP PARTICIPANTS, BY PLAN

Plan	Number of Participants	Total Number of Other Household Members in MCOs
Blue Cross/Blue Shield	6	7
Access MedPlus	5	6
TLC	2	0
OmniCare	3	1
Phoenix	1	0
PruCare	0	0
Refused or Don't Know	2	3

handle eligibility were varied. One Memphis consumer said, "She shouldn't be there if she's not going to read up on how the insurance works." But the rural focus group participants (which included two in the expansion group) had all received help in enrolling from the DHS outreach worker and considered her extremely helpful.'

Two of the urban consumers are enrolled as uninsured and pay premiums. The state's management of premiums is faulty; one consumer has paid her premiums but reported that the state had sent her a letter saying she had not been paying (fortunately, she had her check stubs and could show the state the check numbers). Another had an increase in her income and went off Medicaid into the uninsured group. The caseworker was confused about whether she was still eligible for TennCare, but 6 months later she was still covered and has never received a premium billing (even though she believes she should have). One of the consumers representing a disabled child was also covered by TennCare and previously by Medicaid. She reported being billed for premiums, but she threw away the letter and continues to have coverage. Premium-paying consumers commented that the premiums are very affordable, unlike insurance offered with their own or their spouse's employment, which they could not afford (these consumers may not actually be eligible, even though they are enrolled).

SELECTION OF PLANS

Many consumers did not select a plan when they enrolled because they did not understand that they needed to make a choice; therefore, they were assigned to plans. "I think a lot of us were ignorant about what to do and how the new program was going to work and so maybe a lot of us didn't know exactly what to do and actually I didn't choose my own, they chose for me." Some were not satisfied with the assignment, however, and changed (either right away or at open enrollment). "I never chose my insurance so I got stuck with Blue Cross/Blue Shield, then I sent my papers back in to get changed to Access

[2]These participants in the focus group were selected because they were known to the DHS outreach worker, however, so we cannot assume that everybody in the county had access to her.

MedPlus because no doctors took Blue Cross/Blue Shield." The local DHS outreach worker had advised the rural focus group participants to ask their physician about which plan to choose (there were only two choices for this group--Access MedPlus and Blue Cross).

After consumers had selected or been assigned to a plan, it took about 6 to 8 weeks (and, in one case, 6 months) for them to receive their membership cards (the outlier admitted she moved a lot). Two consumers said they didn't realize they could use services before they got their cards. One child had been sent three plan cards (all from plans other than the plan of the mother and siblings, who were in Blue Cross/Blue Shield); the mother was not sure which of these plans was active.

Since TennCare startup, consumers had learned a lot about how the process works. Several of them had changed plans at open enrollment in October 1994, and others thought they might change at the next open enrollment period (in October 1995). Reasons for changing plans included getting a better choice of physicians and joining a plan (such as Access MedPlus) that offered extra benefits. One consumer complained that she tried to enroll her children in a different plan from the one she' was in, but that the whole family had been enrolled in the same plan. (The state policy is to enroll all family members in one plan, but it sometimes meant that somebody in the family, either mother or children, had to change doctors.) The focus group functioned as an information exchange, with consumers advising each other about their experiences with enrollment and different plans and explaining how the state tried to put families into the same plan. Several consumers indicated that different family members were in different plans (although this was usually when one of the family members was disabled and others were not),

RELATIONSHIPS WITH PRIMARY CARE PROVIDERS

Some consumers had selected their primary care physician. Others had been assigned a physician by their plan, either because they did not realize they had to choose one or because the plan had assigned an interim physician they could change during a limited follow-up period. The urban low-income focus group members least often chose their own doctor; only two out of seven had done so. By the time the focus

groups were held, the consumers understood that TennCare was about limited choice of physicians. (They commented that the lists of doctors made it look like there is a choice, but it's more apparent than real, because when you call they won't necessarily take you.) Some consumers, however, still did not know how to change primary care physicians and were frustrated because they had tried unsuccessfully to get their clinics to make the change for them (instead of approaching their plan). The mother of a child assigned to a general practitioner instead of a pediatrician had this problem; she wanted to change the physician but did not understand how to. The other focus group members offered her a lot of advice about how to change.

Most of the consumers were fairly satisfied with their primary care physicians, although there were exceptions. One disabled consumer had to change physicians when he enrolled in TennCare because his previous physician (a specialist who saw him for all his needs) was not accepting TennCare patients. He frequently needed specialist attention for pain management but had to get a referral from his primary care physician for every specialist visit. In addition, this primary care physician was in an area he did not like to go to. Another consumer said that a doctor had "given her the wrong treatment." Another explained that, after changing physicians, she was told to administer medications differently to her child. One consumer spoke of uncaring physicians--she said her doctor was "not a people person" and gave her prescriptions when she wanted a physical; she had complained about him to her plan. On the other hand, another consumer specifically said she did not feel discriminated against for being a TennCare enrollee and another "loved" the care she received.

Access to primary care physicians (appointments and travel times) was generally satisfactory to the participants (1 to 5 days), although a few complained of long waits to appointments (more than 2 weeks), and two complained about the location of the physician (one was a long travel time out into the suburbs from center city, and another was the opposite). One consumer with tonsillitis was told by her physician's office that she would have to wart several days for an appointment, so she went to the emergency room at

Methodist hospital. The hospital called her physician and was able to get her an appointment with her physician for the next day.

One-half of the disabled group was unaware that transportation to medical care was available: "I didn't know; I had no idea." In a low-income group, however, there was a greater awareness of transportation availability: some said that their plan offered a taxi service, and others said that their clinic offered one. Several had used it. One pregnant women explained that you have to order the taxi service several days ahead of time and that's how she got to her regularly scheduled prenatal appointments. Most of the consumers had a car or could get somebody to take them for an appointment, however.

One of the consumers talked about problems getting access to the emergency room in Memphis for her child. This consumer said that the children's hospital had refused to see her child for bronchitis because they weren't accepting her plan (Le Bonheur did stop accepting nonemergency Access MedPlus members). Therefore, she went to the "evening clinic" (a primary care clinic for after hours) "and when I took her across the street to the evening clinic, they referred me right back to Le Bonheur; they called the paramedics because she was too sickly [for me to take her back]."

Providers had billed several consumers, even though they are covered by a TennCare plan. One said, "I'm not exactly sure what I'm supposed to pay out of my pocket and what the plan pays for." One said she handled these bills by throwing them away. Another was not sure if she was supposed to be paying for an X ray that she was being billed for, and another was billed for an ambulance that took her son to Le Bonheur hospital (but which she has not paid for). Another explained that her disabled husband has to pay for prescription drugs and then get reimbursed later by the plan; this is a hardship because the drugs are very expensive. Some were paying copayments on services such as vision care for adults (offered by Access MedPlus); one said she paid $10 for a visit and contact lenses.

The consumers do not seem to be using out-of-plan services a great deal. One consumer paid out of pocket for a physical exam at the family-planning clinic because her primary care doctor would not examine her (she said he doesn't like examining her).

ACCESS TO SPECIALIZED CARE

The consumers understood that they had to have a referral slip from their primary care physicians to see a specialist (unless they were in Blue Cross/Blue Shield), but they were not aware of the efforts the physicians described undertaking to get these referrals. Most consumers were satisfied with their access to specialty care (an exception was the disabled consumer noted earlier who had trouble accessing a specialist for pain management). The disabled group in Memphis was especially concerned about what would happen to their access to specialty care if The Med closed down. They were extremely happy with The Med and the specialists there, used The Med in emergencies regardless of which plan they were in, and were very critical of Access MedPlus (which they said had not been paying the hospitals, and thus was causing financial problems at The Med).

COMPARISON WITH MEDICAID AND PRIVATE INSURANCE

Virtually none of the focus group participants had recent experience with private insurance. One who had been enrolled in a private plan noted the very high cost of the plan ($150 a month) and the fact that, when she needed services during her pregnancy, none of them was covered. Many of the consumers had experience with Medicaid before TennCare; the principal differences they talked about were the greater choice of doctors under Medicaid, the fact that they had had to change doctors under TennCare, the differences in prescription drug coverage, and difficulties accessing dentists.

Having to change doctors was a major problem for some consumers because they had to get used to a new doctor; in one case, it had made specialty access very difficult. However, the bottom line for patients

was the doctor's personality and whether they were treated well; most were very pleased with their TennCare doctors, even when they had not chosen them themselves.

Medicaid limited the number of prescriptions to seven, while the TennCare plans restrict which drugs they cover. TennCare is more of a problem because some consumers have had to switch drugs, and in the early days of TennCare they had trouble finding pharmacies that would fill their prescriptions. One consumer wanted to know why some birth control pills were covered and others were not. Memphis consumers reported that different pharmacies in the same chain had different policies for over-the-counter medications such as vitamins; some did not charge, while others did.

Children's access to dentists under TennCare is problematic in the rural area. Some plans offer dental care to adults, but none of those who had adult coverage were using it because of difficulties finding dentists who accept TennCare patients.

HEALTH CARE ALTERNATIVES

In the rural area, consumers appear to be seeing the same physicians that they did before joining TennCare. In the urban areas, consumers who had had a physician often had to change when they were enrolled, some because they did not make an active choice of plan or physician, some because the state switched them to a different plan than the one they chose, and some because their previous doctor did not participate in TennCare. In Memphis, The Med (and Le Bonheur for children) seemed to be everybody's back-up source of care. That was where they used to go for care, and many continued to go there regardless of their plan and physician assignment. As the hospitals narrow which plans they will accept and open clinics to divert primary care from their emergency rooms, these patterns will be disrupted.

OTHER ISSUES

The focus group participants were very aware of the attitudes of their providers to TennCare, the financial difficulties The Med is in, and the differences in payments among plans. They talked about how

low the payments were under Blue Cross and how Access MedPlus didn't pay its hospital bills; one described how her hospital had lost money on her admission. The consumers in Memphis also reported that Methodist was the only remaining hospital in town accepting nonemergency Access MedPlus patients